No. 11. An act relating to updating and reorganizing the health insurance statutes in 8 V.S.A. chapter 107.

(S.30)

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

* * * Repeal of Existing 8 V.S.A. Chapter 107 * * *

Sec. 1. REPEAL OF EXISTING 8 V.S.A. CHAPTER 107

8 V.S.A. chapter 107 (health insurance) is repealed.

* * * Enactment of Updated and Reorganized 8 V.S.A. Chapter 107 * * *

Sec. 2. 8 V.S.A. chapter 107 is added to read:

CHAPTER 107. HEALTH INSURANCE

Subchapter 1. General Provisions

§ 4011. DEFINITIONS

As used in this chapter:

(1) "Covered individual" means an individual who is covered by a health insurance plan, whether as the primary subscriber or policyholder or as a dependent, employee, or employee's dependent under the plan.

(2) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(3) "Health insurance plan" means a policy or contract issued by a health insurer, including the health benefit plan or plans offered by the State of Vermont to its employees and any health benefit plan offered by any agency or instrumentality of the State to its employees. Unless otherwise specified, "health insurance" does not include Vermont Medicaid.

(4) "Health insurer" means an insurance company that provides health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, a managed care organization, a health maintenance organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by a public or private entity.

(5) "Major medical insurance" means a comprehensive health insurance plan that is not specific disease, accident, hospital indemnity, dental care, vision care, disability income, long-term care, Medicare supplement insurance, or other limited-benefit coverage. The term does not include short-term, limited-duration health insurance coverage or a plan under which benefits are paid directly to a covered individual or the individual's assigns and for which the amount of the benefit is not based on potential medical costs or on actual costs incurred.

§ 4012. COMPLIANCE WITH FEDERAL LAW

(a) Except as otherwise provided in this title, health insurers, hospital and medical service corporations, and health maintenance organizations that issue, sell, renew, or offer health insurance plans in Vermont shall comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (42 U.S.C. Chapter 6A, Subchapter XXV), and 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. The Commissioner shall enforce such requirements pursuant to the Commissioner's authority under this title.

(b)(1) Health insurers, hospital and medical service corporations, health maintenance organizations, and health care providers, as that term is defined in 18 V.S.A. § 9432, shall comply with the requirements of the No Surprises Act, Pub. L. No. 116-260, Division BB, Title I, as amended from time to time.

(2) The Commissioner shall enforce the requirements of the No Surprises Act as they apply to health insurers, hospital and medical service corporations, health maintenance organizations, and health care providers, to the extent permitted under federal law, pursuant to the Commissioner's authority under this title. The Commissioner may also refer cases of noncompliance to the U.S. Department of Health and Human Services under the terms of a collaborative enforcement agreement, or to the Office of the Vermont Attorney General.

§ 4013. DISCRIMINATION PROHIBITED

No health insurer shall make or permit any unfair discrimination between individuals of substantially the same hazard in the amount of premium rates charged for any health insurance plan or in the benefits payable under the plan; provided, however, that this section shall not be construed to prohibit different premium rates, different benefits, or different underwriting procedure for individuals insured under group, family expense, or blanket plans of insurance.

§ 4014. ADVERTISING PRACTICES

(a) No company doing business in this State, and no insurance agent or broker, shall use in connection with the solicitation of health insurance or pharmacy benefit management any advertising copy or advertising practice or any plan of solicitation that is materially misleading or deceptive. An advertising copy or advertising practice or plan of solicitation shall be considered to be materially misleading or deceptive if by implication or otherwise it transmits information in such manner or of such substance that a prospective applicant for health insurance may be misled by it to the applicant's material damage.

(b)(1) If the Commissioner finds that any such advertising copy or advertising practice or plan of solicitation is materially misleading or deceptive, the Commissioner shall order the company or the agent or broker using such copy or practice or plan to cease and desist from such use.

(2) Before making any such finding and order, the Commissioner shall give notice, not less than 10 days in advance, and a hearing to the company, agent, or broker affected.

(3) If the Commissioner finds, after due notice and hearing, that any authorized insurer, licensed pharmacy benefit manager, licensed insurance agent, or licensed insurance broker has intentionally violated any such order to cease and desist, the Commissioner may suspend or revoke the license of such insurer, pharmacy benefit manager, agent, or broker.

§ 4015. PENALTIES FOR VIOLATIONS

The Commissioner may impose an administrative penalty of up to $750.00 on any person who intentionally violates any provision of this chapter or any order of the Commissioner made in accordance with this chapter. The Commissioner may also suspend or revoke the license of a health insurer or agent for any such intentional violation.

§ 4016. APPEAL

(a) Any person aggrieved by any action of the Commissioner may obtain a review by appeal to the Superior Court of Washington County. The appeal shall be based on the record of the proceedings before the Commissioner and shall not be limited to questions of law. If the appeal is from an order of the Commissioner, the order shall not take effect during the pendency of the appeal unless the court determines otherwise.

(b) The court may review all the facts and in disposing of any issue before it may modify, affirm, or reverse any order of the Commissioner in whole or in part.

(c) Either party may appeal from the decision of the Superior Court to the Supreme Court in the manner provided by law.

§ 4017. EXEMPTION FROM ATTACHMENT AND TRUSTEE PROCESS

So much of any benefits under all policies of health insurance as does not exceed $200.00 for each month during any period of disability covered by the policy shall not be liable to attachment, trustee process, or other process, or to

be seized, taken, appropriated, or applied by any legal or equitable process or by operation of law, either before or after payment of such benefits, to pay any debt or liabilities of the person insured under the policy. However, this exemption shall not apply where an action is brought to recover for necessaries contracted for during the period of disability and the writ or bill of complaint contains a statement to that effect. When a policy provides for a lump sum payment because of a dismemberment or other loss insured, the payment shall be exempt from execution of the covered individual's creditors.

§ 4018. THIRD-PARTY OWNERSHIP

Nothing in this chapter shall be construed as preventing a person other than the covered individual with proper insurable interest from making application for and owning a policy covering the covered individual or from being entitled under such a policy to any indemnities, benefits, and rights provided in the policy.

§ 4019. NOTICE AS WAIVER

A health insurer shall not be deemed to have waived any rights to defend a claim under a health insurance plan based solely on the health insurer's acknowledgement of receipt of notice under the plan, furnishing or accepting forms for filing proof of loss under the plan, or investigating any claim of loss under the plan.

§ 4020. AGE LIMITS

(a) If a health insurance plan contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the plan will not be effective, and if that date falls within a period for which the health insurer has accepted a premium or if the health insurer accepts a premium after that date, the coverage provided by the plan shall continue in force subject to any right of cancellation until the end of the period for which a premium has been accepted.

(b) Notwithstanding any provision of subsection (a) of this section to the contrary, if the age of the covered individual has been misstated and if, according to the correct age of the covered individual, the coverage provided by the policy would not have become effective or would have ceased prior to the health insurer's acceptance of the premium or premiums, then the health insurer's liability shall be limited to the refund, upon request, of all premiums paid for the period not covered by the plan.

§ 4021. TERMINATION OF COVERAGE

(a)(1) A major medical insurance policy issued by a health insurer that insures employees, members, or subscribers for hospital and medical insurance on an expense-incurred, service, or prepaid basis shall:

(A) provide notice to the policyholder or other responsible party of any premium payment due on a policy at least 21 days before the due date; and

(B) provide a grace period of at least one month for the payment of each premium falling due after the first premium, during which grace period the plan shall continue in force and the issuer of the plan shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

(2) If the issuer of a plan described subdivision (1) of this subsection does not receive payment by the due date, the issuer shall send a termination notice to the policyholder at least 21 days prior to termination notifying the policyholder that the issuer may terminate the plan if payment is not received by the termination date.

(3) The termination date of a plan described in subdivision (1) of this subsection shall not be earlier than the day following the last day of the grace period set forth in subdivision (1)(A) of this subsection.

(b) For all health insurance policies other than major medical insurance policies, a health insurer shall notify a policyholder of any premium payment due on a policy at least 21 days before the due date. If a health insurer does not receive payment by the due date, the health insurer shall send a termination notice to the policyholder notifying the policyholder that the health insurer will terminate the policy effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice. If a health insurer does not receive payment within 14 days from the date of mailing of the termination notice, the health insurer may cancel coverage effective on the due date.

§ 4022. REBATES AND COMMISSIONS PROHIBITED FOR NONGROUP AND SMALL GROUP POLICIES AND PLANS OFFERED THROUGH THE VERMONT HEALTH BENEFIT EXCHANGE

(a) No health insurer doing business in this State and no insurance agent or broker shall:

(1) offer, promise, allow, give, set off, or pay, directly or indirectly:

(A) any rebate of or part of the premium payable on a health insurance plan issued pursuant to 33 V.S.A. § 1811 or earnings, profits, dividends, or other benefits founded, arising, accruing, or to accrue on or from the premium;

(B) any special advantage in date of policy or age of issue;

(C) any paid employment or contract for services of any kind;

(D) any other valuable consideration or inducement to or for insurance on any risk in this State, or for or upon any renewal of any such insurance, that is not specified in the health insurance plan; or

(2) offer, promise, give, option, sell, or purchase any stocks, bonds, securities, or property, or any dividends or profits accruing or to accrue on them, or other thing of value as inducement to insurance or in connection with insurance, or any renewal thereof, that is not specified in the health insurance plan.

(b) No person insured under a health insurance plan issued pursuant to 33 V.S.A. § 1811 or party or applicant for such plan shall directly or indirectly

receive or accept or agree to receive or accept any rebate of premium or of any part of the premium, or any favor or advantage, or share in any benefit to accrue under any health insurance plan issued pursuant 33 V.S.A. § 1811, or any valuable consideration or inducement, that is not specified in the health insurance plan.

(c) Nothing in this section shall be construed as prohibiting any health insurer from:

(1) allowing or returning to its participating policyholders dividends, savings, or unused premium deposits;

(2) returning or otherwise abating, in full or in part, the premiums of its policyholders out of surplus accumulated from nonparticipating insurance; or

(3) taking a bona fide obligation, with interest not exceeding six percent per annum, in payment of any premium.

(d)(1) No insurer 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 of a health insurance plan issued pursuant to 33 V.S.A. § 1811, nor shall a health insurer include in an insurance rate for a health insurance plan issued pursuant to 33 V.S.A. § 1811 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 particular health insurance plans over other plans offered by that insurer.

(2) Nothing in this subsection shall be construed to prohibit the Vermont Health Benefit Exchange established in 33 V.S.A. chapter 18, subchapter 1 from structuring compensation for agents or brokers in the form of an additional commission, fee, or other compensation outside insurance rates or from compensating agents, brokers, or other individuals through the procedures and payment mechanisms established pursuant to 33 V.S.A. § 1805(17).

§ 4022a. REBATES PROHIBITED FOR GROUP INSURANCE POLICIES

(a) As used in this section, "group insurance" means any policy described in section 4041 of this title, except that it shall not include any small group policy issued pursuant to 33 V.S.A. § 1811.

(b) No health insurer doing business in this State and no insurance agent or broker shall:

(1) offer, promise, allow, give, set off, or pay, directly or indirectly:

(A) any rebate of or part of the premium payable on a group insurance policy, or on any group insurance policy or agent's commission on the premium or earnings, profits, dividends, or other benefits founded, arising, accruing, or to accrue on or from the premium;

(B) any special advantage in date of policy or age of issue;

(C) any paid employment or contract for services of any kind; or

(D) any other valuable consideration or inducement to or for insurance on any risk in this State, or for or upon any renewal of any such insurance, that is not specified in the health insurance plan; or

(2) offer, promise, give, option, sell, or purchase any stocks, bonds, securities, or property, or any dividends or profits accruing or to accrue on them, or other thing of value as inducement to insurance or in connection with insurance, or any renewal thereof, that is not specified in the health insurance plan.

(c) No person insured 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 of the premium, or all or any part of any agent's or broker's commission on the premium, or any favor or advantage, or share in any benefit to accrue under any health insurance plan, or any valuable consideration or inducement, that is not specified in the health insurance plan.

(d) Nothing in this section shall be construed as prohibiting:

(1) the payment of commission or other compensation to any duly licensed agent or broker;

(2) any health insurer from allowing or returning to its participating policyholders dividends, savings, or unused premium deposits;

(3) any health insurer from returning or otherwise abating, in full or in part, the premiums of its policyholders out of surplus accumulated from nonparticipating insurance; or

(4) the health insurer from taking a bona fide obligation, with interest not exceeding six percent per annum, in payment of any premium.

(e) A health insurer that pays a 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 health insurer in connection with the sale of a group insurance policy shall clearly disclose to the purchaser of the policy the amount of any such commission, fee, or compensation paid or to be paid.

§ 4023. PROVISIONS APPLYING TO POLICIES DELIVERED IN ANOTHER STATE

If any policy is issued by a health insurer domiciled in this State for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of the other state informs the Commissioner that the policy is not subject to approval or disapproval by the official, the Commissioner may issue an order requiring that the policy meet the standards set forth in sections 4029, 4030, and 4031 of this title.

§ 4024. COORDINATION OF INSURANCE COVERAGE WITH MEDICAID AND COMPLIANCE WITH MEDICAID RECOVERY PROVISIONS

(a) No health insurer shall consider the availability of or eligibility for medical assistance in this or any other state under Title XIX of the Social Security Act (Medicaid) when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders.

(b) A health insurer that issues, sells, renews, or offers health insurance coverage in Vermont or who is required to be licensed or registered with the Department shall comply with the requirements of 33 V.S.A. §§ 1907, 1908, 1909, and 1910. The Commissioner shall enforce such requirements pursuant to the Commissioner's authority under this title.

§ 4025. HEALTH INSURANCE AND THE BLUEPRINT FOR HEALTH

(a) All major medical insurance plans shall be offered, issued, and administered consistent with the Blueprint for Health established in 18 V.S.A. chapter 13.

(b) Health insurers offering major medical insurance plans shall participate in the Blueprint for Health as specified in 18 V.S.A. § 706.

Subchapter 2. Policy Forms and Filing Requirements

§ 4026. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy filed by a health insurer and not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this State, nor shall any endorsement, rider, or application that becomes a part of any such policy be used, until a copy of the form and of the rules for the classification of risks has been filed with the Department of Financial Regulation and a copy of the premium rates has been filed with the Green Mountain Care Board, and the Green Mountain Care Board has issued a decision approving, modifying, or disapproving the proposed rate.

(2)(A) The Green Mountain Care Board shall review rate requests and shall approve, modify, or disapprove a rate request within 90 calendar days after receipt of an initial rate filing from a health insurer. If a health insurer fails to provide necessary materials or other information to the Board in a timely manner, the Board may extend its review for a reasonable additional period of time, not to exceed 30 calendar days.

(B) Prior to the Board's decision on a rate request, the Department of Financial Regulation shall provide the Board with an analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves.

(3) The Board shall determine whether a rate is affordable; promotes quality care; promotes access to health care; protects insurer solvency; and is

not unjust, unfair, inequitable, misleading, or contrary to the laws of this State. In making this determination, the Board shall consider the analysis and opinion provided by the Department of Financial Regulation pursuant to subdivision (2)(B) of this subsection.

(b)(1) In conjunction with a rate filing required by subsection (a) of this section, a health insurer shall file a plain language summary of the proposed rate. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human Services (HHS) requires for rate increases over 10 percent, and any other information required by the Board. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.

(2)(A) In conjunction with a rate filing required by subsection (a) of this section, a health insurer shall disclose to the Board:

(i) for all covered prescription drugs, including generic drugs, brand-name drugs excluding specialty drugs, and specialty drugs dispensed at a pharmacy, network pharmacy, or mail-order pharmacy for outpatient use:

(I) the percentage of the premium rate attributable to prescription drug costs for the prior year for each category of prescription drugs;

(II) the year-over-year increase or decrease, expressed as a percentage, in per-member, per-month total health plan spending on each category of prescription drugs; and

(III) the year-over-year increase or decrease in per-member, per-month costs for prescription drugs compared to other components of the premium rate; and

(ii) the specialty tier formulary list.

(B) The insurer shall provide, if available, the percentage of the premium rate attributable to prescription drugs administered by a health care provider in an outpatient setting that are part of the medical benefit as separate from the pharmacy benefit.

(C) The insurer shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subdivisions (A) and (B) of this subdivision (2) are managed by the pharmacy benefit manager, as well as the name of the pharmacy benefit manager or managers used.

(3)(A) Upon request, in conjunction with a rate filing required by subsection (a) of this section, a health insurer shall provide to the Board detailed information about the insurer's payments to specific providers, which

may include fee schedules, payment methodologies, and other payment information specified by the Board.

(B) Confidential business information and trade secrets received from a health insurer pursuant to subdivision (A) of this subdivision (3) shall be exempt from public inspection and copying under 1 V.S.A. § 317(c)(9) and shall be kept confidential, except that the Board may disclose or release information publicly in summary or aggregate form if doing so would not disclose confidential business information or trade secrets.

(C) Notwithstanding 1 V.S.A. chapter 5, subchapter 2 (Vermont Open Meeting Law), the Board may examine and discuss confidential information outside a public hearing or meeting.

(c)(1) The Board shall provide information to the public on the Board's website about the public availability of the filings and summaries required under this section.

(2)(A) The Board shall post the rate filings pursuant to subsection (a) of this section and summaries pursuant to subsection (b) of this section on the Board's website within five calendar days following filing. The Board shall also establish a mechanism by which members of the public may request to be notified automatically each time a proposed rate is filed with the Board.

(B) The Board shall provide an electronic mechanism for the public to comment on all rate filings. The Board shall accept public comment on each rate filing from the date on which the Board posts the rate filing on its website

pursuant to subdivision (A) of this subdivision (2) until 15 calendar days after the Board posts on its website the analyses and opinions of the Department of Financial Regulation and of the Board's consulting actuary, if any, as required by subsection (d) of this section. The Board shall review and consider the public comments prior to issuing its decision.

(3)(A) In addition to the public comment provisions set forth in this subsection, the Office of the Health Care Advocate established in 18 V.S.A. chapter 229, acting on behalf of health insurance consumers in this State, may, within 30 calendar days after the Board receives a health insurer's rate request pursuant to this section, submit to the Board, in writing, suggested questions regarding the filing for the Board to provide to its contracting actuary, if any.

(B) The Office of the Health Care Advocate may also submit to the Board written comments on a health insurer's rate request. The Board shall post the comments on its website and shall consider the comments prior to issuing its decision.

(d)(1) Not later than 60 calendar days after receiving a health insurer's rate request pursuant to this section, the Green Mountain Care Board shall make available to the public the insurer's rate filing, the Department's analysis and opinion of the effect of the proposed rate on the insurer's solvency, and the analysis and opinion of the rate filing by the Board's contracting actuary, if any.

(2) The Board shall post on its website, after redacting any confidential or proprietary information relating to the insurer or to the insurer's rate filing:

(A) all questions the Board poses to its contracting actuary, if any, and the actuary's responses to the Board's questions; and

(B) all questions the Board; the Board's contracting actuary, if any; or the Department poses to the insurer and the insurer's responses to those questions.

(e) Within the time period set forth in subdivision (a)(2)(A) of this section, the Board shall:

(1) conduct a public hearing, at which the Board shall:

(A) call as witnesses the Commissioner of Financial Regulation or designee and the Board's contracting actuary, if any, unless all parties agree to waive such testimony; and

(B) provide an opportunity for testimony from the insurer, the Office of the Health Care Advocate, and members of the public;

(2) at a public hearing, announce the Board's decision of whether to approve, modify, or disapprove the proposed rate; and

(3) issue its decision in writing.

(f)(1) The insurer shall notify its policyholders of the Board's decision in a timely manner, as defined by the Board by rule.

(2) Rates shall take effect on the date specified in the insurer's rate filing.

(3) If the Board has not issued its decision by the effective date specified in the insurer's rate filing, the insurer shall notify its policyholders of its pending rate request and of the effective date proposed by the insurer in its rate filing.

(g) A health insurer, the Office of the Health Care Advocate, and any member of the public with party status, as defined by the Board by rule, may appeal a decision of the Board approving, modifying, or disapproving the insurer's proposed rate to the Vermont Supreme Court.

(h)(1) The authority of the Board under this section shall apply only to the rate review process for policies for major medical insurance coverage and shall not apply to the policy forms for major medical insurance coverage or to the rate and policy form review process for policies for specific disease, accident, injury, hospital indemnity, dental care, vision care, disability income, long-term care, student health insurance coverage, Medicare supplement insurance coverage, or other limited benefit coverage; to short-term, limited-duration health insurance coverage; or to benefit plans that are paid directly to an individual insured or to the individual's assigns and for which the amount of the benefit is not based on potential medical costs or actual costs incurred. Premium rates and rules for the classification of risk for Medicare supplement insurance policies shall be governed by section 4051 of this title.

(2) The policy forms for major medical insurance coverage, as well as the policy forms, premium rates, and rules for the classification of risk for the

other lines of insurance described in subdivision (1) of this subsection shall be reviewed and approved or disapproved by the Commissioner. In making a determination, the Commissioner shall consider whether a policy form, premium rate, or rule is affordable and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; and, for a policy form for major medical insurance coverage, whether it ensures equal access to appropriate mental health care in a manner equivalent to other aspects of health care as part of an integrated, holistic system of care. The Commissioner shall make a determination within 30 days after the date the insurer filed the policy form, premium rate, or rule with the Department. At the expiration of the 30-day period, the form, premium rate, or rule shall be deemed approved unless prior to then it has been affirmatively approved or disapproved by the Commissioner or found to be incomplete. The Commissioner shall notify a health insurer in writing if the insurer files any form, premium rate, or rule containing a provision that does not meet the standards expressed in this subsection. In such notice, the Commissioner shall state that a hearing will be granted within 20 days upon the insurer's written request.

(i) Notwithstanding the procedures and timelines set forth in subsections (a) through (e) of this section, the Board may establish, by rule, a streamlined rate review process for certain rate decisions, including proposed rates affecting fewer than a minimum number of covered lives and proposed rates for which a de minimis increase, as defined by the Board by rule, is sought.

§ 4027. FILING FEES

Each filing of a policy, contract, or document form or premium rates or rules, submitted pursuant to section 4026 of this title, shall be accompanied by payment to the Commissioner or the Green Mountain Care Board, as appropriate, of a nonrefundable fee of $150.00.

§ 4028. FORM AND CONTENTS OF POLICY

No policy of individual health insurance shall be delivered or issued for delivery to any person in this State unless all of the following conditions are met:

(1) The policy sets forth all of the monetary and other considerations for the policy.

(2) The policy sets forth the time at which the insurance takes effect and terminates.

(3) The policy purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including a spouse or civil union partner, dependent children or any children under a specified age that shall not exceed 26 years of age, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed

in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point with a lowercase unspaced alphabet length not less than 120-point. As used in this subdivision, the "text" includes all printed matter except the name and address of the insurer; the name or title of the policy; the brief description, if any; and the captions and subcaptions.

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those that are set forth in sections 4029 and 4030 of this title, are printed, at the insurer's option, either with the benefit provision to which they apply or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS"; provided, however, that if an exception or reduction specifically applies only to a particular benefit of the policy, the statement of the exception or reduction shall be included with the benefit provision to which it applies.

(6) Each policy form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page of the form.

(7) The policy does not contain any provision purporting to make any portion of the charter, rules, constitution, or bylaws of the health insurer a part of the policy unless that portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks or a short-rate table filed with the Commissioner.

(8) Either prominently printed on or attached to the first page of the policy is a notice to the effect that during a period of 30 days following the

date the policy is delivered to persons eligible for Medicare by reason of age, and 10 days following the date of delivery to all other persons, the policy may be surrendered to the insurer together with a written request for cancellation of the policy, and that in such event, the insurer will refund any premium paid, including any policy fees or other charges; provided, however, that this subdivision shall not apply to single premium nonrenewable policies insuring against accident only or medical costs or accidental bodily injury only.

§ 4029. REQUIRED STANDARD POLICY PROVISIONS

Except as provided in section 4031 of this title, each health insurance policy delivered or issued for delivery to any person in this State shall contain the provisions specified in this section using the language set forth in this section; provided, however, that a health insurer may, at its option, substitute different language approved by the Commissioner for one or more provisions, provided the substituted language is not less favorable in any respect to the insured or covered individual than the language used in this section. The provisions specified in this section shall be preceded individually by the caption appearing in this section or, at the option of the health insurer, by such appropriate captions or subcaptions as the Commissioner may approve:

(1) ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or

attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) TIME LIMIT ON CERTAIN DEFENSES: (a) After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy, shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three-year period.

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial three-year period, nor to limit the application of subdivisions 4030(1)–(5) of this title in the event of misstatement with respect to age or occupation or other insurance.) (A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

(b) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3) GRACE PERIOD: A grace period of . . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision,

subject to the right of the insurer to cancel in accordance with the cancellation provision hereof,

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his or her last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.)

(4) REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by

the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least five years from its date of issue.)

(5) NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at . . . . (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he or she shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.)

(6) CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . . (insert period for

payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $. . . . . (insert an amount which shall not exceed $1,000.00), to any relative by blood or connection by civil marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.)

(10) PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and the opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relative to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

§ 4030. OPTIONAL STANDARD POLICY PROVISIONS

Except as provided in section 4031 of this title, no health insurance policy delivered or issued for delivery to any person in this State shall contain provisions respecting the matters set forth in this section unless the provisions use the language set forth in this section; provided, however, that a health insurer may, at its option, substitute different language approved by the Commissioner for one or more provisions, provided the substituted language is not less favorable in any respect to the insured or covered individual than the language used in this section. Any provision set forth in this section that is contained in the policy shall be preceded individually by the appropriate caption appearing in this section or, at the option of the health insurer, by such appropriate captions or subcaptions as the Commissioner may approve:

(1) CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his or her occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his or her occupation to one classified by the insurer as less hazardous than that

stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for .... (insert type of coverage or coverages) in excess of $ ..... (insert maximum limit of indemnity or indemnities) the excess

insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his or her estate.

or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his or her beneficiary or his or her estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "—EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage.")

(5) INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase "—OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the Commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with

respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage.")

(6) RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his or her average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200.00 or the sum of the monthly benefits specified

in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50; or (2) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

(7) UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his or her last address as

shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(9) CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(10) ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

§ 4031. OMISSION OF INAPPLICABLE OR INCONSISTENT STANDARD PROVISIONS

If any provision of sections 4029 and 4030 of this title is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the health insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

§ 4032. ORDER OF STANDARD POLICY PROVISIONS

The provisions specified in sections 4029 and 4030 of this title, or any corresponding provisions used in lieu of those provisions as permitted by those sections, shall either be printed in the same order as the provisions are set forth in those sections or, at the option of the health insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

§ 4033. DISCRETIONARY CLAUSES PROHIBITED

(a) The purpose of this section is to ensure that health insurance benefits, disability income protection coverage, and life insurance benefits are contractually guaranteed and to avoid the conflict of interest that may occur

when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. Nothing in this section shall be construed to impose any requirement or duty on any person other than a health insurer or a health insurer offering disability income protection coverage or life insurance.

(b) As used in this section:

(1) "Disability income protection coverage" means a policy, contract, certificate, or agreement that provides for weekly, monthly, or other periodic payments for a specified period during the continuance of disability resulting from illness, injury, or a combination of illness and injury.

(2) "Health insurer" has the same meaning as in section 4021 of this chapter and, as used in this section, also includes entities offering policies for specific disease, accident, injury, hospital indemnity, dental care, disability income, long-term care, and other limited benefit coverage.

(3) "Life insurance" means a policy, contract, certificate, or agreement that provides life insurance as defined in subdivision 3301(a)(1) of this title.

(c) No policy, contract, certificate, or agreement offered or issued in this State by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services may contain a provision purporting to reserve discretion to the health insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

(d) No policy, contract, certificate, or agreement offered or issued in this State providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

(e) No policy, contract, certificate, or agreement of life insurance offered or issued in this State shall contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

§ 4034. REQUIREMENTS OF OTHER JURISDICTIONS

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this State, may contain any provision that is not less favorable to the covered individual than the provisions of this chapter and that is prescribed or required by the law of the state under which the insurer is organized.

(b) Any policy of a domestic health insurer, when issued for delivery in any other state or country, may contain any provision permitted or required by the laws of such other state or country.

§ 4035. POLICIES NOT AFFECTED

Nothing in sections 4018–4020, 4023, 4028–4032, 4034, 4036, and 4037 of this title shall apply to or affect:

(1) any policy of workers' compensation insurance or any policy of liability insurance, with or without supplementary coverage;

(2) any policy or contract of reinsurance;

(3) any blanket or group policy of insurance enumerated in sections 4041–4043 and 4052 of this title, except as otherwise provided in those sections; or

(4) life insurance, endowment, or annuity contracts, or contracts supplemental to those contracts, that contain only such provisions relating to accident and sickness insurance as:

(A) provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(B) operate to safeguard the contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

§ 4036. NONCONFORMING POLICIES

(a) A health insurance policy shall not contain any provision that makes the policy or any portion of the policy less favorable in any respect to the covered

individual than the provisions of the policy that are regulated by sections 4029 and 4030 of this title.

(b) A policy delivered or issued for delivery to any person in this State in violation of sections 4029 and 4030 of this title shall be held valid but shall be construed as provided in this chapter. When any provision in a policy regulated by sections 4029 and 4030 is in conflict with any provision of those sections, the rights, duties, and obligations of the health insurer and the covered individual shall be governed by the provisions of those sections.

§ 4037. APPLICATIONS FOR INSURANCE

(a)(1) A covered individual shall not be bound by any statement made in an application for a policy unless a copy of the application is attached to or endorsed on the policy as a part of the policy when issued.

(2) If a policy delivered or issued for delivery to any person in this State is reinstated or renewed and the covered individual or assignee of the policy makes a written request to the health insurer for a copy of the application, if any, for such reinstatement or renewal, the health insurer shall deliver or mail a copy of the application to the individual making the request within 15 days after the receipt of the request. If the health insurer does not deliver or mail the copy within 15 days, the health insurer shall be precluded from introducing the application as evidence in any action or proceeding based on or involving the policy or its reinstatement or renewal.

(b) No alteration of a written application for a policy shall be made by any person other than the applicant without the applicant's written consent, except that insertions may be made by the health insurer, for administrative purposes only, in a manner that indicates clearly that the insertions are not to be ascribed to the applicant.

(c) The falsity of any statement in an application for a policy shall not bar the right to recovery under the policy unless the false statement materially affected either the acceptance of the risk or the hazard assumed by the health insurer.

§ 4038. RULEMAKING ON POLICY FILINGS

The Commissioner may adopt such reasonable rules concerning the procedure for the filing or submission of policies subject to sections 4023 and 4028–4030 of this title as are necessary, proper, or advisable for the administration of these sections. This provision shall not abridge any other authority granted to the Commissioner by law.

Subchapter 3. Group Coverage

§ 4041. GROUP HEALTH INSURANCE POLICIES; DEFINITIONS

(a) As used in this section:

(1) "Employees" includes the officers, managers, and employees of the employer; the partners, if the employer is a partnership; the officers, managers, and employees of subsidiary or affiliated corporations of a corporation employer; and the individual proprietors, partners, and employees of

individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise.

(2) "Employer" may be deemed to include any municipal or governmental entity or officer, or the appropriate officer for an unincorporated town or gore or for the Unified Towns and Gores of Essex County, as well as private individuals, partnerships, and corporations.

(b) Group health insurance is a form of health insurance that covers one or more persons, with or without their dependents, that is issued upon the following basis:

(1)(A) Under a policy issued to an employer, who is deemed the policyholder, insuring at least one employee of the employer, for the benefit of persons other than the employer.

(B) In accordance with section 3368 of this title, an employer domiciled in a jurisdiction other than Vermont that has more than 25 certificate-holder employees whose principal worksite and domicile is in Vermont and that is defined as a large group in its own jurisdiction and under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1304, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, may purchase insurance in the large group health insurance market for its Vermont-domiciled certificate-holder employees.

(2)(A) Under a policy issued:

(i) to an association, a trust, or one or more trustees of a fund established by one or more associations otherwise eligible for the issuance of a policy under this subdivision (2) and maintained, directly or indirectly, by one or more associations for the benefit of its members or a contract or plan issued by such an association or trust; or

(ii) by a multiple employer welfare arrangement as defined in the Employee Retirement Income Security Act of 1974, as amended.

(B)(i) The association or associations shall have:

(I) a minimum of 100 persons at the time of incorporation or formation;

(II) been organized and maintained in good faith for purposes other than that of obtaining insurance;

(III) been in active existence for at least one year; and

(IV) a constitution and bylaws that provide that:

(aa) the association or associations hold regular meetings not less than annually to further purposes of the members;

(bb) except for credit unions, the association or associations collect dues or solicit contributions from members; and

(cc) the members constitute a majority of the voting power of the association for all purposes and have representation on the governing board and committees.

(ii)(I) The association or associations shall not be controlled by a health insurer, as evidenced by the operation of the association or associations.

(II) The following factors may be used as evidence to determine whether an association is a health insurer-operated association; provided, however, that the presence or absence of one or more of these factors shall not serve to limit or be dispositive of such a determination:

(aa) common board members, officers, executives, or employees;

(bb) common ownership of the health insurer and the association, or of the association and another eligible group; and

(cc) common use of office space or equipment used by the health insurer to transact insurance.

(C) An association's members shall have a shared or common purpose that is not primarily a business or customer relationship.

(D)(i) A policy issued by an association shall not insure persons other than the members or employees of the association or associations, or employees of members, or all of any class or classes of employees of the association, associations, or members, together, in each case, with the employees' or members' dependents, as applicable, for the benefit of persons other than the employee's employer.

(ii) A policy issued by an association shall insure all eligible persons, except those who reject coverage in writing.

(E) An association shall not use the solicitation of insurance as the primary method of obtaining new members.

(F) If a health insurer collects membership fees or dues on behalf of an association, the health insurer shall disclose to the members of the association that the health insurer is billing and collecting membership fees and dues on behalf of the association.

(3)(A) Under a policy issued to a trust, or to one or more trustees of a fund established and maintained, directly or indirectly, by:

(i) two or more employers;

(ii) one or more labor unions or similar employee organizations; or

(iii) one or more employers and one or more labor unions or similar employee organizations.

(B)(i) A policy under this subdivision (3) must be issued to the trust or trustees for the purpose of insuring all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members, together, in each case, with the employees' or members' dependents, as applicable, for the benefit of persons other than the employers or the unions or organizations.

(ii) A policy issued to a trust shall insure all eligible persons, except those who reject coverage in writing.

(4) Under a policy issued to any other substantially similar group that, in the discretion of the Commissioner, may be subject to the issuance of a group accident and sickness policy or contract.

§ 4042. GROUP INSURANCE POLICIES; REQUIRED POLICY PROVISIONS

(a) Terms and conditions. No group health insurance policy shall contain any provision relating to notice of claim, proofs of loss, time of payment of claims, or time within which legal action must be brought upon the policy 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 4029 of this title. In addition, each such policy shall contain in substance the following provisions:

(1) A provision that the policy; the application of the policyholder, if an application or copy is attached to the policy; and the individual applications, if any, submitted by the employees or members in connection with the policy shall constitute the entire contract between the parties, and that all statements, in the absence of fraud, made by any applicant or applicants shall be deemed representations and not warranties, and that no such statement shall avoid the insurance or reduce benefits under the policy unless contained in a written application, of which a copy is attached to the policy.

(2) A provision that the health insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual

certificate setting forth in summary form a statement of the essential features of the insurance coverage of the employee or member and to whom benefits are payable under the policy. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) A provision that the health insurer shall not exclude part-time employees and shall offer the same group health benefits to part-time employees as it offers to the employee groups of which the part-time employees would be members if they were full-time employees. The health insurer shall offer to include the part-time employees as part of the employer's employee group, at the full rate to be paid by the employer and the employee, at a rate prorated between the employer and the employee, or at the employee's expense. As used in this subdivision, "part-time employee" means any employee who works a minimum of at least 17.5 hours per week.

(b) Protections for covered individuals.

(1) Preexisting condition exclusions. 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.

(2) Annual limitations on cost sharing.

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

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

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

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

(3) Ban on annual and lifetime limits. A group insurance policy shall not establish any annual or lifetime limit on the dollar amount of essential health benefits, as defined in Section 1302(b) of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health

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

(4) No cost sharing for preventive services.

(A) A group insurance policy shall not impose any co-payment, coinsurance, or deductible requirements for:

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

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

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

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

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

(5) Definition of "group insurance policy." As used in this subsection, "group insurance policy" has the same meaning as "group health plan" and shall be subject to the same excepted benefits, in each case, as set forth in 45 C.F.R. § 146.145, as in effect as of December 31, 2017.

§ 4043. ASSOCIATION HEALTH PLANS

(a)(1) As used in this section, "association health plan" means a policy issued to an association; to a trust; or to one or more trustees of a fund established, created, or maintained for the benefit of the members of one or more associations or a contract or plan issued by an association or trust or by a multiple employer welfare arrangement as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

(2) No association health plan shall be issued, offered, or renewed in this State to any person other than an association that was formed or could have been formed under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et. seq., and accompanying U.S. Department of Labor regulations and guidance, in each case, as in effect as of January 19, 2017.

(b) The Commissioner shall adopt rules pursuant to 3 V.S.A. chapter 25 regulating association health plans in order to protect Vermont consumers and promote the stability of Vermont's health insurance markets, to the extent

permitted under federal law, including rules regarding licensure, solvency and reserve requirements, and rating requirements.

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

Subchapter 4. Continuation and Conversion of

Group Health Insurance Policies

§ 4047a. CONTINUATION OF GROUP

(a) All group major medical insurance and dental insurance policies shall provide that any person whose insurance under the group policy would terminate because of the occurrence of a qualifying event as defined in subsection (b) of this section shall be entitled to continue the person's health insurance under that group policy.

(b) For purposes of this subchapter, "qualifying event" means:

(1) loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage;

(2) divorce, dissolution, or legal separation of the covered employee from the employee's spouse or civil union partner;

(3) a dependent child ceasing to qualify as a dependent child under the generally applicable requirements of the policy; or

(4) death of the covered employee or member.

(c) The provisions of this section shall not apply if one or more of the following conditions applies:

(1) The deceased person or employee was not insured under the group policy on the date of the qualifying event.

(2) The person is covered by Medicare.

(3) The person is covered by any other group insured or uninsured arrangement that provides dental coverage or hospital and medical coverage for individuals in a group and under which the person was not covered immediately prior to the qualifying event, and no preexisting condition exclusion applies; provided, however, that the person shall remain eligible for continuation coverages that are not available under the insured or uninsured arrangement.

(4) The person has a loss of employment due to misconduct as defined in 21 V.S.A. § 1344.

(d) The continuation required by this section only applies to major medical insurance and dental insurance benefits.

(e) Notice of the continuation privilege shall be included in each certificate of coverage and shall be provided by the employer to the employee within 30 days following the occurrence of any qualifying event.

§ 4047b. CONTINUATION; NOTICE; TERMS

(a) A person electing continuation shall notify the health insurer, or the policyholder, or the contractor, or agent for the group if the policyholder did not contract for the policy directly with the health insurer, of such election in writing within 60 days after receiving notice following the occurrence of a

qualifying event pursuant to subsection 4047a(e) of this title. Notice of election to continue under the group policy shall be accompanied by the initial contribution, which shall include payment for the period from the qualifying event through the end of the month in which the election is made.

(b) Contributions shall be due on a monthly basis in advance to the health insurer or the health insurer's agent, and shall not be more than 102 percent of the group rate for the insurance being continued under the group policy on the due date of each payment.

§ 4047c. TERMINATION OF COVERAGE

Continuation of insurance under the group policy shall terminate upon the occurrence of any of the following:

(1) The date 18 months after the date that insurance under the policy would have terminated due to a qualifying event, as defined in subsection 4047a(b) of this title.

(2) The person fails to make timely payment of the required contribution.

(3) The person is covered by Medicare.

(4) The person is covered by any other group insured or uninsured arrangement that provides dental coverage or hospital and medical coverage for individuals in a group, under which the person was not covered immediately prior to the occurrence of a qualifying event, as defined in subsection 4047a(b) of this title, and no preexisting condition exclusion

applies; provided, however, that the person shall remain eligible for continuation coverages that are not available under the insured or uninsured arrangement.

(5) The date on which the group policy is terminated or, in the case of an employee, the date on which the decedent's or terminated employee's employer terminates participation under the group policy. If such coverage is replaced by similar coverage under another group policy:

(A) the person shall have the right to become covered under that replacement policy for the balance of the period that the person would have remained covered under the prior group policy;

(B) the minimum level of benefits to be provided by the replacement policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy; and

(C) the prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement has not occurred.

Subchapter 5. Group Health Insurance Termination and Replacement

§ 4048a. DEFINITIONS; POLICIES AND CONTRACTS COVERED

(a) As used in this subchapter, "group health insurance policy or subscriber contract" means a policy or contract that meets the following conditions:

(1) coverage is provided through insurance policies or subscriber contracts to classes of employees or members of an organization or group;

(2) the coverage is not available to the general public and can be obtained and maintained only because of the covered individual's employment or membership in an organization or group;

(3) there are arrangements for bulk payment of premiums or subscription charges to the health insurer; and

(4) there is sponsorship of the plan by the employer, organization, or group.

(b) A group health insurance policy or subscriber contract shall not be issued or provided by a health insurer unless the policy or contract complies with the provisions of this subchapter and the rules adopted pursuant to this subchapter.

§ 4048b. TERMINATION FOR NONPAYMENT OF PREMIUM OR SUBSCRIPTION CHARGES

(a) If a group health insurance policy or subscriber contract provides for automatic termination of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the health insurer shall be liable for valid claims for covered losses incurred prior to the end of the grace period.

(b) If the actions of the health insurer after the end of the grace period indicate that it considers the policy or contract to be continuing in force beyond the end of the grace period, including actions such as continuing to recognize claims subsequently incurred, the health insurer shall be liable for valid claims

for losses incurred prior to the effective date of written notice of termination to the policyholder or other entity responsible for making payments or submitting subscription charges to the health insurer.

(c) The health insurer shall notify a policyholder or other responsible entity of any premium payment due on a policy at least 21 days before the due date. The effective date of termination of a policy or contract shall not be prior to midnight at the end of the 14th day following mailing of notice of termination.

§ 4048c. NOTICE OF TERMINATION

(a) A notice of termination of a health insurer's group health insurance policy or subscriber contract shall:

(1) request the group policyholder or other entity involved to notify employees or members covered under the policy or subscriber contract of the date of termination of the policy or contract and to advise the employees or members that, unless otherwise provided in the policy or contract, the health insurer shall not be liable for claims for losses incurred after such date; and

(2) advise, in any instance in which the plan involves employee contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of termination, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

(b) The health insurer giving notice of termination shall prepare and furnish to the policyholder or other entity at the time of notice a supply of a notice

form to be distributed to covered employees or members. The form shall state the fact of termination and the effective date of termination. The form shall contain a statement directing employees or members to refer to their certificates or contracts in order to determine their rights.

§ 4048d. EXTENSION OF BENEFITS

(a) Each group health insurance policy or subscriber contract shall provide a reasonable extension of benefits in the event that the employer or member is in a condition of total disability on the date of termination of the group policy or contract in accordance with the provisions of this section.

(b) A policy or contract providing benefits for loss of time from work or specific indemnity during hospital confinement shall provide that termination of the policy or contract during a loss of time or confinement shall have no effect on benefits payable for the loss of time or confinement.

(c) A policy or contract providing hospital or medical expense coverage benefits shall provide an extension of benefits of at least 12 months under major medical insurance coverage and at least 90 days under other types of hospital or medical expense coverage.

(d) The provisions of a policy or contract relating to extension of benefits or accrued liability shall be described in the policy or contract as well as in group insurance certificates. The benefits payable during a period of extension or accrued liability may be subject to the policy's or contract's regular benefit limits.

(e) Nothing in this section shall be construed to require an extension of dental benefits.

§ 4048e. REPLACEMENT COVERAGE

(a) General. When the group health insurance policy or subscriber contract of a health insurer replaces a policy or contract providing similar benefits of another health insurer, the liability of both health insurers shall be as provided in this section and rules adopted pursuant to this section.

(b) Liability of prior health insurer. A prior health insurer remains liable after termination of its policy or contract only to the extent of its accrued liabilities and extensions of benefits.

(c) Liability of succeeding health insurer.

(1) A succeeding health insurer shall offer a group health insurance policy or subscriber contract to replace a prior health insurer's policy or contract in accordance with the provisions of this subsection.

(2) A succeeding health insurer shall offer a policy or contract to cover all persons who:

(A) are covered or are a member of a class eligible for coverage under the prior health insurer's policy or contract on the date of termination of the prior health insurer's policy or contract; or

(B) are a member of a class eligible for coverage under the succeeding health insurer's policy or contract on the date of termination of the prior health insurer's policy or contract.

(3) The succeeding health insurer is not liable under this subsection for benefits required to be paid by the prior health insurer.

(4) When replacing a prior health insurer's plan that is not subject to section 4048d of this title, the succeeding health insurer shall, in addition to the coverage required to be offered under subdivision (2) of this subsection, offer a policy or contract that provides a level of benefit equal to the lesser of:

(A) the extension of benefits that would have been required if the prior health insurer's policy or contract was subject to section 4048d of this title; or

(B) the extension of benefits required for the succeeding health insurer's policy or contract, except that any such benefits may be reduced by benefits actually payable under the prior health insurer's plan.

(5) The preexisting condition limitation of a succeeding health insurer's policy or contract shall provide a level of benefits equal to the lesser of:

(A) the benefits of the succeeding health insurer's policy or contract determined without application of the preexisting conditions limitation; or

(B) the benefits of the prior health insurer's policy or contract.

(6) The succeeding health insurer, in applying a deductible or waiting-period provision in its policy or contract, shall give credit for the satisfaction of the same or similar provisions under the prior health insurer's policy or contract.

(7) At the succeeding health insurer's request, the prior health insurer shall furnish all information needed to determine the benefits available under the prior health insurer's policy or contract.

(d) Rules. The Commissioner shall adopt rules necessary to carry out the purposes of this section.

Subchapter 6. Other Forms of Health Coverage

§ 4051. MEDICARE SUPPLEMENT INSURANCE POLICIES

(a) Community rating.

(1) A health insurer shall use a community rating method acceptable to the Commissioner for determining premiums for Medicare supplement insurance policies.

(2) The Commissioner shall adopt rules for standards and procedure for permitting health insurers that issue Medicare supplement insurance policies to use one or more risk classifications in their community rating method. The premium charged shall not deviate from the community rate and the rules shall not permit medical underwriting and screening, except that a health insurer may set different community rates for persons eligible for Medicare by reason of age and persons eligible for Medicare by reason of disability.

(b) Premium increases.

(1) Within five days after receiving a request for approval of any composite average rate increase in excess of three percent, or any other coverage changes that the Commissioner determines will have a comparable

impact on cost or availability of coverage for a Medicare supplement insurance policy issued by any health insurer with 5,000 or more total lives in the Vermont Medicare supplement insurance market, the Commissioner shall notify the Department of Disabilities, Aging, and Independent Living of the proposed premium increase. A composite average rate is the enrollment-weighted average rate increase of all plans offered by a health insurer.

(2) Within five days after receiving notification pursuant to subdivision (1) of this subsection, the Department of Disabilities, Aging, and Independent Living shall inform the members of the Advisory Board established pursuant to 33 V.S.A. § 505 of the proposed premium increase.

(3)(A) The Commissioner shall not approve any request to increase Medicare supplement insurance premium rates unless the amount of the rate increase complies with the statutory standards for approval under sections 4026, 4513, 4584, and 5104 of this title. Any approved rate increase shall not be based on an unreasonable change in loss ratio from the previous year, unless the Commissioner makes written findings that such change is necessary to prevent a substantial adverse impact on the financial condition of the health insurer. In acting on such rate increase requests, the Commissioner may deny the request, approve the rate increase as requested, or approve a rate increase in an amount different from the increase requested. A decision by the Commissioner other than an approval of the rate requested may be appealed by the health insurer, provided that the burden of proof shall be on the health

insurer to show that the approved rate does not meet the statutory standards established under this subsection.

(B) Before acting on the rate increase requested, the Commissioner may make such examination or investigation as the Commissioner deems necessary, including where applicable the review process set forth in subdivision (C) of this subdivision (3).

(C)(i) In reviewing any Medicare supplement insurance rate increase for which an independent analysis has been performed pursuant to 33 V.S.A. § 6706 and in which the health insurer's requested composite average increase, the independent expert's recommended composite average rate increase, or the Department actuary's recommended composite average rate increase differ by two percentage points or more, the Commissioner shall hold a public hearing at which the health insurer, the Department's actuary, the independent expert, any intervenor, and the public will have the opportunity to present written and oral testimony and will be available to answer questions of the Commissioner and those present.

(ii) The hearing shall be noticed and held at a time and place so as to facilitate public participation, and shall be recorded and become part of the record before the Commissioner. At the Commissioner's discretion, the hearing may be conducted remotely.

(iii) If the carrier's requested composite average increase, the independent expert's recommended composite average increase, or the

Department actuary's recommended composite average increase differs by less than two percentage points, the Department and the parties shall confer by conference call, or by any other available media, to review the rate requests and recommendations. However, a public hearing may be held at the Commissioner's discretion for good cause shown.

(D)(i) In any review held in accordance with this subdivision (3), the Commissioner shall permit intervention by any person whom the Commissioner determines will materially advance the interests of the covered individuals. The intervenor shall have access to and may use the information of the independent expert appointed under 33 V.S.A. § 6706.

(ii) The reasonable and necessary cost of intervention as determined by the Commissioner shall be paid by the affected policyholders or certificate holders. The maximum payment shall be $2,500.00 except when waived by the Commissioner for good cause shown. The $2,500.00 maximum amount may be adjusted to reflect, at the Commissioner's discretion, appropriate inflation factors.

(E) Nonproprietary, relevant information in any Medicare supplement insurance rate filing, including any analysis by the Department's actuary and the independent expert, shall be made available to the public upon request.

(c) Disability.

(1) A health insurer that issues Medicare supplement insurance policies or certificates to a person eligible for Medicare by reason of age shall make available, to persons eligible for Medicare by reason of disability, the same policies or certificates that are offered and sold to persons eligible for Medicare by reason of age. The initial enrollment period for any such policies or certificates shall be at least six months following the date the individual becomes eligible for Medicare by reason of disability. Any additional enrollment periods as required by law and offered to individuals eligible by reason of age shall be offered to individuals eligible by reason of disability.

(2) This subsection does not apply to persons eligible for Medicare by reason of end stage renal disease.

(d) Outreach and education. The Department of Financial Regulation shall collaborate with health insurers, advocates for older Vermonters and for other Medicare-eligible adults, and the Office of the Health Care Advocate to educate the public about the benefits and limitations of Medicare supplement insurance policies and Medicare Advantage plans, including information to help the public understand issues relating to coverage, costs, and provider networks.

§ 4052. BLANKET HEALTH INSURANCE

(a) Blanket health insurance is a form of health insurance that, to the extent permitted under federal law, is supplemental to major medical health insurance

or provides coverage other than the payment of all or a portion of the cost of health care services or products, and that covers special groups of persons as follows:

(1) under a policy or contract issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such common carrier;

(2) under a policy or contract issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment;

(3) under a policy or contract issued to a public school, independent school, or approved education program, as those terms are defined in 16 V.S.A. § 11; to a postsecondary school, as defined in 16 V.S.A. § 176(b)(1); or to a prequalified private prekindergarten provider, as defined in 16 V.S.A. § 829(a)(3), or to the head or principal of the school, program, or provider, who or which shall be deemed the policyholder, covering students or teachers, or both;

(4) under a policy or contract issued in the name of any volunteer fire department, emergency medical services provider, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of the department or group in connection with their department or group activities; or

(5) under a policy or contract issued to any other substantially similar group that, in the discretion of the Commissioner and after the prior approval by the Commissioner of the group, may be subject to the issuance of a blanket health policy or contract.

(b)(1) No blanket health insurance policy shall contain any provision relating to notice of claim, proofs of loss, time of payment of claims, or time within which legal action must be brought upon the policy 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 4029 of this title.

(2) An individual application shall not be required from a person covered under a blanket health policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

(3) All benefits under any blanket health policy shall, unless for hospital and physician service or surgical benefits, be payable to the person insured, or to the person's designated beneficiary or beneficiaries, or to the person's estate, except that if the person insured is a minor, the benefits may be made payable to the minor's parent, guardian, or other person actually supporting the minor.

(4) Nothing in this section shall be deemed to affect the legal liability of policyholders for the death of, or injury to, any members of the group.

(c) No blanket health insurance policy that provides coverage for the payment of all or a portion of the cost of health care services or products shall

contain any provision that does not comply with a requirement of this title, or a rule adopted pursuant to this title applicable to health insurance, other than those requirements applicable to nongroup health insurance or small group health insurance. The Commissioner may waive the application to a blanket insurance policy of one or more of the health insurance requirements of this title, or a rule adopted pursuant to this title, if the requirement is not relevant to the types of risks and duration of risks insured against in the blanket insurance policy.

§ 4053. SHORT-TERM, LIMITED-DURATION HEALTH INSURANCE

(a) As used in this section, "short-term, limited-duration health insurance" means health insurance that provides medical, hospital, or major medical expense benefits coverage pursuant to a policy or contract with a health insurer and that has an expiration date specified in the policy or contract that is three months or less after the original effective date of the policy or contract.

(b) No person shall provide short-term, limited-duration health insurance coverage without a certificate of authority from the Commissioner to offer health insurance in this State unless the person is exempted by subdivision 3368(a)(4) of this title.

(c) A short-term, limited-duration health insurance policy or contract shall be nonrenewable, and a health insurer shall not issue a short-term, limited-duration health insurance policy or contract to any person if the issuance would

result in the person being covered by short-term, limited-duration health insurance coverage for more than three months in any 12-month period.

(d) A policy or contract for short-term, limited-duration health insurance coverage shall display prominently in the policy or contract and in any application materials provided in connection with enrollment in that coverage, in at least 14-point type, certain disclosures regarding the scope of short-term, limited-duration health insurance coverage, including the types of benefits and consumer protections that are and are not included. The Commissioner shall determine the specific disclosure language that shall be used in all short-term, limited-duration health insurance policies, contracts, and application materials and shall provide the language to the health insurers offering that coverage.

(e) The Commissioner shall adopt rules pursuant to 3 V.S.A. chapter 25:

(1) establishing the minimum financial, marketing, service, and other requirements for registration of a health insurer to provide short-term, limited-duration health insurance coverage to individuals in this State;

(2) requiring a health insurer seeking to provide short-term, limited-duration health insurance coverage to individuals in this State to file its rates and forms with the Commissioner for the Commissioner's approval;

(3) requiring a health insurer seeking to provide short-term, limited-duration health insurance coverage to individuals in this State to file its advertising materials with the Commissioner for the Commissioner's approval; and

(4) establishing such other requirements as the Commissioner deems necessary to protect Vermont consumers and promote the stability of Vermont's health insurance markets.

(f) The provisions of section 4063 of this title, and any rules adopted under that section, shall apply to short-term, limited-duration health insurance coverage.

Subchapter 7. Child and Dependent Coverage

§ 4057. COVERAGE OF CHILDREN

(a) Definition. "Health insurance plan" has the same meaning as in section 4011 of this chapter and shall be subject to the same excepted benefits, in each case, as set forth in 45 C.F.R. § 146.145, as in effect as of December 31, 2017.

(b) Newborn coverage.

(1) A health insurance plan that provides dependent coverage of children shall also provide that health insurance benefits applicable to children are payable with respect to a newly born child of the insured or subscriber from the moment of birth. Coverage for a newly born child shall include coverage of injury, sickness, and necessary care and treatment of medically diagnosed congenital defect or birth abnormality.

(2) Coverage for a newly born child shall be provided without notice or additional premium for not less than 60 days after the date of birth. If payment of a specific premium or subscription fee is required in order to have the coverage continue beyond such 60-day period, the policy may require that

notification of the birth of the newly born child and payment of the required premium or fees be furnished to the health insurer within a period of not less than 60 days after the date of birth.

(c) Adopted child coverage.

(1) As used in this section:

(A) "Child" means, in connection with any adoption or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

(B) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

(2) In any case in which a health insurance plan provides coverage for dependent children of covered individuals, the plan shall provide benefits to dependent children placed with covered individuals for adoption under the same terms and conditions as apply to the natural, dependent children of the covered individuals, irrespective of whether the adoption has become final.

(3) A health insurance plan shall not restrict coverage under the plan of any dependent child adopted by a covered individual, or placed with a covered individual for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage

under the plan, if the adoption or placement for adoption occurs while the covered individual is eligible for coverage under the plan.

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

(e) Coverage of adult child with a disability.

(1) A health insurance plan that provides for terminating the coverage of a dependent child upon attainment of the limiting age for dependent children specified in the policy shall not limit or restrict coverage with respect to an unmarried child who meets all of the following criteria:

(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;

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

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

(2) Coverage under subdivision (1) of this subsection shall not be denied any person based upon the existence of such a condition; provided, however, that a health insurance plan may require reasonable periodic proof of a continuing condition not more frequently than once every year.

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

(g) Parental rights. When a child has health coverage through the health insurer of a parent, the health insurer shall:

(1) provide such information to either parent as may be necessary for the child to obtain benefits through that coverage;

(2) permit either parent, a provider with parental authorization, the State Medicaid agency as assignee, or any State agency administering health benefits or a health benefit plan for which Medicaid is a source of funding to submit claims for covered services, and to appeal the denial of any benefit, without the approval of the other parent; and

(3) make payments on claims submitted in accordance with subdivision (2) of this subsection directly to the parent who paid the provider, the provider as assignee, the State Medicaid agency, or any State agency administering health benefits or a health benefit plan for which Medicaid is a source of funding.

(h) Child vaccine coverage. No health insurer shall reduce its coverage for pediatric vaccines below the coverage provided as of May 1, 1993.

§ 4058. MEDICAL SUPPORT ORDERS

(a) As used in this section:

(1) "Dependent coverage" means family coverage, or coverage for one or more persons as long as the coverage for one or more persons is greater than or equal to the coverage available under family coverage.

(2) "Health insurance plan" has the same meaning as in section 4011 of this chapter and shall be subject to the same excepted benefits, in each case, as set forth in 45 C.F.R. § 146.145, as in effect as of December 31, 2017.

(b) A health insurer shall not deny enrollment of a child under the health insurance plan of the child's parent who is ordered to provide medical support on the grounds that:

(1) the child was born to unmarried parents;

(2) the child is not claimed as a dependent on the parent's federal tax return; or

(3) the child does not reside with the parent or in the health insurer's service area.

(c) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for dependent health coverage, the health insurer shall be required:

(1) To enroll, under the dependent coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions or any seasonal restrictions on switching from one plan to another, upon application of either parent, the employer, the State agency administering the Medicaid program, any State agency administering health benefits or a health insurance plan for which Medicaid is a source of funding, or the child support enforcement program.

(2) Not to disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that:

(A) the court or administrative order is no longer in effect;

(B) the child is or will be enrolled in comparable health coverage through another health insurer that will take effect not later than the effective date of disenrollment; or

(C) the employer has eliminated dependent health coverage for all of its employees if allowed by law.

(3) To provide enrollment under subdivision (1) of this subsection with coverage effective three days after the mailing of notice of the court or administrative order to the health insurer or upon actual receipt of notice by the health insurer, whichever is sooner. The health insurer shall have 10 days from notice to process the enrollment and shall be entitled to premiums from the effective date of enrollment.

(d) A health insurer shall not impose requirements on a State agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the health insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(e) Any health insurer that fails to enroll a child after notice under 15 V.S.A. § 663(d) or 33 V.S.A. § 4110(a)(4) shall be directly liable for any medical expenses of the child that would have been covered under the health insurance plan had the health insurer enrolled the child upon receiving notice.

(f) Notice by first class mail, postage prepaid, or by any other method showing actual receipt, shall be presumptive evidence of its receipt by the health insurer to whom it is addressed. Any period of time that is determined under this section by the giving of notice shall commence to run from the date of mailing, if the notice is mailed, or the date of actual receipt if another method of transmitting the notice is used.

(g) A health insurer may cancel any health insurance plan that is the subject of a medical support order for nonpayment of premium only if the health insurer mails or delivers notice of cancellation to both parents and all other persons or agencies identified in the medical support order. Any health insurer cancelling a health insurance plan for nonpayment of premium shall reinstate the health insurance plan effective from the date of cancellation if the nonpayment of premium is cured within 45 days of the cancellation.

§ 4059. COVERAGE FOR CIVIL UNIONS

(a) As used in this section:

(1) "Dependent coverage" means family coverage or coverage for one or more persons.

(2) "Party to a civil union" has the same meaning as in 15 V.S.A. § 1201.

(b) Notwithstanding any provision of law to the contrary, health insurers shall provide dependent coverage to parties to a civil union that is equivalent to that provided to covered individuals who are married. A health insurance

policy that provides coverage for a spouse or family member of the covered individual shall also provide the equivalent coverage for a party to a civil union.

§ 4060. COVERAGE FOR EMPLOYEES OF AN EMPLOYER DOMICILED OUTSIDE VERMONT

(a) As used in this section:

(1) "Marriage" has the same meaning as in 15 V.S.A. § 8.

(2) "Party to a civil union" has the same meaning as in 15 V.S.A. § 1201.

(b) To the extent permitted under federal law, health insurance coverage provided to Vermont residents who work for an employer domiciled outside Vermont shall not distinguish between parties to a civil union, married same-sex couples, and married opposite-sex couples.

Subchapter 8. Internal and External Reviews

§ 4063. INDEPENDENT EXTERNAL REVIEW OF HEALTH CARE SERVICE DECISIONS

(a) As used in this section, "covered individual" includes a member of a health insurance plan not otherwise subject to the Department's jurisdiction that has voluntarily agreed to use the external review process provided under this section.

(b) A covered individual who has exhausted all applicable internal review procedures provided by the health insurance plan shall have the right to an

independent external review of a decision under a health insurance plan to deny, reduce, or terminate health care coverage or to deny payment for a health care service. The independent review shall be available when requested in writing by the affected covered individual, provided the decision to be reviewed requires the plan to expend at least $100.00 for the service and the decision by the plan is based on one of the following reasons:

(1) The health care service is a covered benefit that the health insurer has determined to be not medically necessary.

(2) A limitation is placed on the selection of a health care provider that is claimed by the covered individual to be inconsistent with limits imposed by the health insurance plan and any applicable laws and rules.

(3) The health care treatment has been determined to be experimental or investigational or is an off-label drug. A health insurance plan that denies use of a prescription drug for the treatment of cancer as not medically necessary or as an experimental or investigational use shall treat any internal appeal of such denial as an emergency or urgent appeal and shall decide the appeal within the time frames applicable to emergency and urgent internal appeals under rules adopted by the Commissioner.

(4) The health care service involves a medically based decision that a condition is preexisting.

(5) The decision involves an adverse determination related to surprise medical billing, as established under Section 2799A-1 or 2799A-2 of the

Public Health Service Act, including with respect to whether an item or service that is the subject of the adverse determination is an item or service to which Section 2799A-1 or 2799A-2 of the Public Health Service Act, or both, applies.

(c) The right to review under this section shall not be construed to change the terms of coverage under a health insurance plan.

(d) The Department shall adopt rules necessary to carry out the purposes of this section. The rules shall ensure that the independent external reviews have the following characteristics:

(1) The independent external reviews shall be conducted:

(A) by independent review organizations pursuant to a contract with the Department, and the reviewers shall include health care providers credentialed with respect to the health care service under review and shall have no conflict of interest relating to the performance of their duties under this section; and

(B) in accordance with standards of decision making based on objective clinical evidence, shall resolve all issues in a timely manner, and shall provide expedited resolution when the decision relates to emergency or urgent health care services.

(2) A covered individual shall:

(A) Be provided with adequate notice of the covered individual's review rights under this section.

(B) Have the right to use outside assistance during the review process and to submit evidence relating to the health care service.

(C) Pay an application fee of $25.00 for each request for an independent external review of an appealable decision not to exceed a total of $75.00 annually. The application fee may be waived or reduced based on a determination by the Commissioner that the financial circumstances of the covered individual warrant a waiver or reduction. The application fee shall be paid by the health insurer, not the covered individual, if the independent review organization reverses the health insurer's decision to deny payment for a health care service.

(D) Be protected from retaliation for exercising the covered individual's right to an independent external review under this section.

(3) Other costs of the independent review shall be paid by the health insurance plan.

(4) The independent review organization shall issue to both parties a written review decision that is evidence-based. The decision shall be binding on the health insurance plan.

(5) The confidentiality of any health care information acquired or provided to the independent review organization shall be maintained in compliance with any applicable State or federal laws.

(6) The records of, and internal materials prepared for, specific reviews by any independent review organization under this section shall be exempt from public inspection and copying under the Public Records Act.

(e) Decisions relating to the following health care services shall not be reviewed under this section but shall be reviewed by the review process provided by law:

(1) health care services provided by the Vermont Medicaid program or Medicaid benefits provided through a contracted health plan; and

(2) health care services provided to incarcerated individuals by the Department of Corrections.

§ 4064. MENTAL HEALTH SERVICES REVIEW

(a) The purposes of this section are to:

(1) promote the delivery of quality mental health services in a cost-effective manner;

(2) foster the practice of mental health services review as a professional collaborative process, the primary objective of which is to enhance the effectiveness of clinical treatment;

(3) protect clients and patients, employers, and mental health providers by ensuring that review agents are qualified to perform service review activities and to make informed decisions on the appropriateness of mental health care; and

(4) ensure the confidentiality of clients' and patients' mental health records in the performance of service review activities in accordance with applicable State and federal laws.

(b) Definitions. As used in this section:

(1) "License" means a review agent's license granted by the Commissioner.

(2) "Mental health provider" means any individual, corporation, facility, or institution certified or licensed by this State to provide mental health services, including a physician, nurse with recognized psychiatric specialties, hospital or other health care facility, psychologist, clinical social worker, mental health counselor, alcohol or drug abuse counselor, or an employee or agent of such mental health provider acting in the course and scope of employment or an agency related to mental health services.

(3) "Mental health services" mean acts of diagnosis, treatment, evaluation, or advice or any other acts permissible under the health care laws of Vermont, whether performed in an outpatient or institutional setting, and include treatment for substance use disorder.

(4) "Review agent" means a person or entity performing service review activities within one year following the date of submission of a fully compliant application for licensure who is affiliated with, under contract with, or acting on behalf of a business entity in this State and who provides or administers

mental health benefits to members of health insurance plans subject to the Department's jurisdiction, including a health insurer.

(5) "Service review" means any system for reviewing the appropriate and efficient allocation of mental health services given or proposed to be given to a client or patient, or to a group of clients or patients, for the purpose of recommending or determining whether the services should be covered and includes activities of utilization review and managed care, but does not include professional peer review that does not affect reimbursement for or provision of services.

(c) Any person who approves or denies payment, or who recommends approval or denial of payment, for mental health services, or whose review results in approval or denial of payment for mental health services on a case-by-case basis, shall not review these services in this State unless the Commissioner has granted the person a review agent's license. The Commissioner shall adopt rules to implement the provisions of this section, including the procedures and standards for licensure. The rules shall differentiate between health maintenance organizations licensed to do business within this State and other forms of utilization review. The rules shall establish:

(1) A requirement that within 10 business days after receiving a request for them, the review agent shall make available at no cost to the clients, patients, and providers affected by its service review activities the specific

review criteria and standards, credentials of the reviewing professionals, and procedures and methods to be used in evaluating proposed or delivered mental health services.

(2) A time period within which any determination regarding the provision or reimbursement of mental health services shall be made.

(3) A requirement that any determination regarding mental health services rendered or to be rendered to a client or patient that may result in a denial of third-party reimbursement or a denial of precertification for that service shall include the evaluation, findings, and concurrence of a mental health professional whose training and expertise is at least comparable to that of the treating mental health provider.

(4) The type, qualifications, and number of personnel required to perform service review activities.

(5) A requirement that a determination by a review agent that care rendered or to be rendered is inappropriate shall not be made until the review agent has communicated with the patient's attending mental health provider concerning that care. The review shall be prospective or concurrent with the treatment.

(6) A requirement that any determination that care rendered or to be rendered is inappropriate shall include the written evaluation and findings of the review agent.

(7) A procedure for clients, patients, mental health providers, and hospitals to seek prompt reconsideration before an independent review organization pursuant to section 4063 of this title of an adverse decision by a review agent. The external reviewer engaged by the independent review organization shall have training and expertise at least comparable to that of the treating health care provider.

(8) Policies and procedures to ensure that all applicable State and federal laws to protect the confidentiality of individual mental health records are followed.

(9) Policies and procedures that ensure appropriate notification and concurrence of providers and their clients or patients before client or patient interviews are conducted by the review agent.

(10)(A) Prohibition of an agreement between the review agent and a business entity or third-party payor in which payment to the review agent includes an incentive or contingent fee arrangement based on the reduction of mental health services, reduction of length of stay, reduction of treatment, or treatment setting selected.

(B) Nothing in this subdivision (10) shall prohibit capitation arrangements for reimbursement for mental health services.

(C) A clinical decision made by the attending mental health provider regarding continued treatment shall not be construed as a denial of services subject to the provisions of this section.

(d) Reviewing agents shall be subject to the provisions of chapter 129 of this title governing unfair insurance trade practices.

(e) The Commissioner shall have the authority to examine, take administrative action against, and penalize review agents as provided in chapters 3, 101, and 129 of this title. A person who violates any provision of this section or who submits any false information in an application required by this section may be fined not more than $5,000.00 for each violation.

(f) A review agent shall pay a license fee of $200.00 for the year of registration and a renewal fee of $200.00 for each year thereafter. In addition, a review agent shall pay any additional expenses incurred by the Commissioner to examine and investigate an application or an amendment to an application.

(g) The confidentiality of any health care information acquired by or provided to an independent review organization pursuant to section 4063 of this title shall be maintained in compliance with any applicable State or federal laws. Records of, and internal materials prepared for, specific reviews under this section shall be exempt from public inspection and copying under the Public Records Act.

Subchapter 9. Required Covered Benefits

§ 4067. APPLICATION OF SUBCHAPTER

(a) Unless otherwise specified and to the extent not inconsistent with federal law, the benefits required in this subchapter:

(1) apply only to major medical insurance plans;

(2) may be subject to deductibles, co-payment and coinsurance amounts, fee or benefit limits, practice parameters, and utilization review consistent with any applicable rules and guidance adopted by the Department of Financial Regulation; and

(3) do not apply to Vermont Medicaid.

(b) A health insurer may require benefits mandated in this subchapter to be provided by a licensed health care provider under contract with the health insurer; provided, however, that this provision shall not be construed to relieve a health insurance plan from complying with the applicable network adequacy requirements adopted by the Commissioner by rule.

§ 4068. CHIROPRACTIC SERVICES

(a) A health insurance plan shall provide coverage for clinically necessary health care services provided by a chiropractic physician licensed in this State for treatment within the scope of practice described in 26 V.S.A. chapter 10, but limiting adjunctive therapies to physiotherapy modalities and rehabilitative exercises. A health insurance plan does not have to provide coverage for the treatment of any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs.

(b) A health insurer may require that the chiropractic services be provided upon referral from a health care provider under contract with the health insurer.

(c) For silver- and bronze-level qualified health benefit plans and any reflective health benefit plans offered at the silver or bronze level pursuant to 33 V.S.A. chapter 18, subchapter 1, health care services provided by a chiropractic physician may be subject to a co-payment requirement, provided that any required co-payment amount shall be between 125 and 150 percent of the amount of the co-payment applicable to care and services provided by a primary care provider under the plan.

(d) Nothing in this section shall be construed as impeding or preventing either the provision or coverage of health care services by licensed chiropractic physicians, within the lawful scope of chiropractic practice, in hospital facilities on a staff or employee basis.

§ 4069. PROSTHETIC DEVICES

(a) As used in this section, "prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or a leg.

(b) A health insurance plan shall provide coverage for prosthetic devices that is at least equivalent to the coverage provided by the federal Medicare program. Coverage may be limited to the prosthetic device that is the most appropriate model that is medically necessary to meet the patient's medical needs. Any dispute between the covered individual and the carrier concerning coverage and the application of this section shall be subject to independent external review under section 4063 of this title.

(c) A health insurance plan may require prior authorization for prosthetic devices in the same manner and to the same extent as prior authorization is required for any other covered benefit.

(d) A health insurance plan shall provide coverage under this section for the medically necessary repair or replacement of a prosthetic device.

(e) The coverage for prosthetic devices shall not be subject to a deductible, co-payment, or coinsurance provision that is less favorable to a covered individual than the deductible, co-payment, or coinsurance provisions that apply generally to other nonprimary care items and services under the health insurance plan.

§ 4070. HEARING AID COVERAGE IN LARGE GROUP HEALTH INSURANCE PLANS

(a) As used in this section:

(1) "Hearing aid" means any small, wearable electronic instrument or device designed and intended for the ear for the purpose of aiding or compensating for impaired human hearing and any related parts, attachments, or accessories, including earmolds and associated remote microphones that pair with hearing aids to improve word comprehension in difficult listening situations in live or telecommunication settings. The term does not include large-audience assisted listening devices, such as those designed for auditoriums, or stand-alone assisted listening devices that can function without a hearing aid.

(2) "Hearing aid professional services" means the practice of fitting, selecting, dispensing, selling, or servicing hearing aids, or a combination, including:

(A) evaluation for a hearing aid;

(B) fitting of a hearing aid;

(C) programming of a hearing aid;

(D) hearing aid repairs;

(E) follow-up adjustments, servicing, and maintenance of a hearing aid;

(F) ear mold impressions; and

(G) auditory rehabilitation and training.

(3) "Hearing care professional" means an audiologist or hearing aid dispenser licensed under 26 V.S.A. chapter 67, a physician licensed under 26 V.S.A. chapter 23 or 33, a physician assistant licensed under 26 V.S.A. chapter 31, or an advanced practice registered nurse licensed under 26 V.S.A. chapter 28, working within that professional's scope of practice.

(4) "Large group health insurance plan" means a major medical insurance plan that meets the requirements of section 4041 of this title but that is not:

(A) a qualified health benefit plan or reflective health benefit plan offered in accordance with 33 V.S.A. chapter 18, subchapter 1; or

(B) a health benefit plan offered by an intermunicipal insurance association to one or more entities providing educational services pursuant to 24 V.S.A. chapter 121, subchapter 6.

(b)(1) A large group health insurance plan shall cover the cost of a hearing aid for each ear and the associated hearing aid professional services when the hearing aid or aids are prescribed, fitted, and dispensed by a hearing care professional. The coverage shall include hearing aid batteries when prescribed by a hearing care professional.

(2) A large group health insurance plan may limit coverage to not more than one hearing aid per ear every three years, except that a plan shall cover the cost of one or more new hearing aids for a covered individual prior to the expiration of the three-year period based on a hearing care professional's determination that a new hearing aid for one or both ears is medically necessary.

(c)(1) Subject to the limitations set forth in subdivision (b)(2) of this section, the coverage provided by a large group health insurance plan for hearing aids and associated services shall be limited only by medical necessity.

(2) A covered individual may select a hearing aid that exceeds the limits set forth in subdivision (1) of this subsection and pay the additional cost.

(d) The coverage required by this section shall not be subject to a deductible, co-payment, or coinsurance provision that is less favorable to a covered individual than the deductible, co-payment, or coinsurance provisions

that apply generally to other nonprimary care items and services under the large group health insurance plan.

§ 4071. GENDER-AFFIRMING HEALTH CARE SERVICES

(a) As used in this section, "gender-affirming health care services" has the same meaning as in 1 V.S.A. § 150.

(b)(1) A health insurance plan shall provide coverage for gender-affirming health care services that:

(A) are medically necessary and clinically appropriate for the individual's diagnosis or health condition; and

(B) are included in the State's essential health benefits benchmark plan.

(2) Nothing in this section shall prohibit a health insurance plan from providing greater coverage for gender-affirming health care services than is required under this section.

(c) Cost sharing. A health insurance plan shall not impose greater coinsurance, co-payment, deductible, or other cost-sharing requirements for coverage of gender-affirming health care services than apply to the diagnosis and treatment of any other physical or mental condition under the plan.

(d) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. The coverage provided pursuant to this section by Medicaid and other public health care assistance programs shall comply

with any requirements imposed on such coverage by the Centers for Medicare and Medicaid Services.

§ 4072. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

(a) It is the goal of the General Assembly that treatment for mental conditions be recognized as an integral component of health care, that health insurance plans cover all necessary and appropriate medical services without imposing practices that create barriers to receiving appropriate care, and that integration of health care be recognized as the standard for care in this State.

(b) As used in this section:

(1) "Mental condition" means any condition or disorder involving psychiatric disabilities or substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Diseases, as periodically revised.

(2) "Mental health provider" means any individual, corporation, facility, or institution certified or licensed by this State to provide mental health services, including a physician, nurse with recognized psychiatric specialties, hospital or other health care facility, psychologist, clinical social worker, mental health counselor, alcohol or drug abuse counselor, or an employee or agent of such provider acting in the course and scope of employment or an agency related to mental health services.

(3) "Rate, term, or condition" means any lifetime or annual payment limits, deductibles, copayments, coinsurance, and any other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of health insurance coverage that affects the covered individual.

(c) A health insurance plan shall provide coverage for treatment of a mental condition and shall:

(1) not establish any rate, term, or condition that places a greater burden on a covered individual for access to treatment for a mental condition than for access to treatment for other health conditions, including no greater co-payment for primary mental health care or services than the co-payment applicable to care or services provided by a primary care provider under a covered individual's health insurance plan and no greater co-payment for specialty mental health care or services than the co-payment applicable to care or services provided by a specialist provider under a covered individual's health insurance plan;

(2) not exclude from its network or list of authorized providers any licensed mental health or substance use disorder treatment provider located within the geographic coverage area of the health insurance plan if the provider is willing to meet the terms and conditions for participation established by the health insurer;

(3) make any deductible or out-of-pocket limits required under a health insurance plan comprehensive for coverage of both mental and physical health conditions; and

(4) if the health insurance plan provides prescription drug coverage, ensure that at least one medication in each therapeutic class approved by the U.S. Food and Drug Administration for the treatment of substance use disorder, including for opioid use disorder, methadone, buprenorphine, and naltrexone, is available on the lowest cost-sharing tier of the plan's prescription drug formulary.

(d)(1)(A) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental conditions through a managed care organization, provided that the managed care organization is in compliance with rules adopted by the Commissioner that ensure that the system for delivery of treatment for mental conditions does not diminish or negate the purpose of this section. In reviewing policy rates and forms pursuant to section 4026 of this title, the Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, shall consider the compliance of the policy with the provisions of this section.

(B) The rules adopted by the Commissioner shall ensure that:

(i) timely and appropriate access to care is available;

(ii) the quantity, location, and specialty distribution of health care providers is adequate;

(iii) administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any covered individual;

(iv) utilization review and other administrative and clinical protocols do not deter timely and appropriate care, including emergency hospital admissions;

(v) in the case of a managed care organization that contracts with a health insurer to administer the health insurer's mental health benefits, the portion of a health insurer's premium rate attributable to the coverage of mental health benefits is reviewed under section 4026, 4513, 4584, or 5104 of this title to determine whether it is excessive, inadequate, unfairly discriminatory, unjust, unfair, inequitable, misleading, or contrary to the laws of this State;

(vi) the health insurance plan is consistent with the Blueprint for Health with respect to mental conditions;

(vii) a quality improvement project is completed annually as a joint project between the health insurance plan and its mental health managed care organization to implement policies and incentives to increase collaboration among providers that will facilitate clinical integration of services for medical and mental conditions, including:

(I) evidence of how data collected from the quality improvement project are being used to inform the practices, policies, and future direction of care management programs for mental conditions; and

(II) demonstration of how the quality improvement project is supporting the incorporation of best practices and evidence-based guidelines into the utilization review of mental conditions;

(viii) an up-to-date list of active mental health providers in the plan's network is available on the health insurer's and managed care organization's websites and provided to consumers upon request; and

(ix) the health insurers and managed care organizations make accessible to consumers the toll-free telephone number for the Department of Financial Regulation's consumer protection help line.

(C) Prior to the adoption of rules pursuant to this subdivision (d)(1), the Commissioner shall consult with the Commissioner of Mental Health and the task force established pursuant to subsection (h) of this section concerning:

(i) developing incentives and other measures addressing the availability of providers of care and treatment for mental conditions, especially in medically underserved areas;

(ii) incorporating nationally recognized best practices and evidence-based guidelines into the utilization review of mental conditions; and

(iii) establishing benefit design, infrastructure support, and payment methodology standards for evaluating the health insurance plan's

consistency with the Blueprint for Health with respect to the care and treatment of mental conditions.

(2) A managed care organization providing or administering coverage for treatment of mental conditions on behalf of a health insurance plan shall comply with this section, sections 4064 and 4724 of this title, and 18 V.S.A. § 9414; with rules adopted pursuant to those provisions of law; and with all other obligations, under Title 18 and under this title, of the health insurance plan and the health insurer on behalf of which the managed care organization is providing or administering coverage. A violation of any provision of this section shall constitute an unfair act or practice in the business of insurance in violation of section 4723 of this title.

(3) A health insurer that contracts with a managed care organization to provide or administer coverage for treatment of mental conditions is fully responsible for the acts and omissions of the managed care organization, including any violations of this section or a rule adopted pursuant to this section.

(4) In addition to any other remedy or sanction provided for by law, if the Commissioner, after notice and an opportunity to be heard, finds that a health insurance plan or managed care organization has violated this section or any rule adopted pursuant to this section, the Commissioner may:

(A) assess a penalty on the health insurer or managed care organization under section 4726 of this title;

(B) order the health insurer or managed care organization to cease and desist in further violations;

(C) order the health insurer or managed care organization to remediate the violation, including issuing an order to the health insurer to terminate its contract with the managed care organization; and

(D) revoke or suspend the license of a health insurer or managed care organization, or permit continued licensure subject to such conditions as the Commissioner deems necessary to carry out the purposes of this section.

(5) As used in this subsection, the term "managed care organization" includes any of the following entities that provide or administer the coverage of mental health benefits on behalf of a health insurance plan:

(A) a mental health review agent as defined in section 4064 of this title;

(B) a health insurer or its delegate;

(C) a managed care organization, as defined in 18 V.S.A. § 9402, or its delegate; and

(D) any other person or entity that meets the definition of a managed care organization under 18 V.S.A. § 9402 or under rules adopted by the Commissioner.

(e) To be eligible for coverage under this section, the service shall be rendered:

(1) For treatment of a mental condition, either:

(A) by a licensed or certified mental health professional; or

(B) in a mental health facility qualified pursuant to rules adopted by the Secretary of Human Services or in an institution, approved by the Secretary of Human Services, that provides a program for the treatment of a mental condition pursuant to a written plan.

(2) For treatment of substance abuse disorder, either:

(A) by a licensed alcohol and drug abuse counselor or other person approved by the Secretary of Human Services based on rules adopted by the Secretary that establish standards and criteria for determining eligibility under this subdivision; or

(B) in an institution, approved by the Secretary of Human Services, that provides a program for the treatment of substance use disorder pursuant to a written plan.

§ 4073. DIABETES TREATMENT

(a) A health insurance plan shall provide coverage for the equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care professional.

(b) Diabetes outpatient self-management training and education required to be covered by this section shall be provided by a certified, registered, or

licensed health care professional with specialized training in the education and management of diabetes.

§ 4074. TREATMENT OF INHERITED METABOLIC DISORDERS

(a) As used in this section:

(1) "Inherited metabolic disorder" means a disorder caused by an inherited abnormality of body chemistry for which the State screens newborn infants.

(2) "Low protein modified food product" means a food product that is specifically formulated to have less than one gram of protein per serving and is intended to be used under the direction of a health care professional for the dietary treatment of a metabolic disorder.

(3) "Medical food" means an amino acid modified preparation that is intended to be used under the direction of a health care professional for the dietary treatment of an inherited metabolic disorder.

(b) A health insurance plan shall provide coverage for medical foods prescribed for medically necessary treatment for an inherited metabolic disorder.

(c) Coverage for low protein modified food products prescribed for medically necessary treatment of an inherited metabolic disorder shall be at least $2,500.00 during any continuous period of 12 months for any covered individual.

§ 4075. CRANIOFACIAL DISORDERS

(a)(1) A health insurance plan shall provide coverage for diagnosis and medically necessary treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face, neck, or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. Subject to subsection (b) of this section, this coverage shall be the same as that provided under the health insurance plan for any other musculoskeletal disorder in the body and shall be covered when the diagnosis or treatment, or both, is prescribed or administered by a physician or a dentist.

(2) This section shall not be construed to require coverage for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

(b) A health insurance plan may require a referral from a health care provider under contract with the plan.

§ 4076. HOME HEALTH SERVICES

(a) As used in this section:

(1) " Home health agency" means a nonprofit home health agency that has been certified under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.).

(2) "Home health care" means care and treatment provided by a home health agency and designed and supervised by a health care professional, without which care and treatment a person would require admission to a

hospital or skilled nursing facility, as those terms are defined by Medicare regulations. The care and treatment shall consist of one or more of the following:

(A) Part-time or intermittent skilled nursing care.

(B) Physical therapy.

(C) Part-time or intermittent home health aide services that consist primarily of caring for the patient.

(D) Medical supplies, drugs and equipment, and laboratory services to the extent that laboratory services would have been covered if the patient had been admitted to a hospital or skilled nursing facility. The medical necessity of equipment may be reviewed by reference to the Medicare guidelines for durable medical equipment.

(b)(1) A major medical insurance plan shall provide coverage for home health care.

(2) A health insurer may require evidence of insurability as a prerequisite to coverage.

(3) The coverage shall consist of at least 40 visits by a home health agency in any calendar year, or in any continuous period of 12 months, for each person covered under the health insurance plan.

(4) Each visit by a member of a home health care agency, other than a home health aide, shall be considered one home health care visit, and four

hours of home health aide service shall be considered one home health care visit. Coverage shall be provided for maternity and childbirth.

(c) Nothing in this section shall be deemed to require that home health care coverage be provided to individuals eligible for Medicare.

(d) A health insurance plan shall not impose greater coinsurance, co-payment, deductible, or other cost-sharing requirements for coverage of home health care than apply to the diagnosis and treatment of any other physical or mental condition under the plan.

§ 4077. REPRODUCTIVE HEALTH CARE SERVICES

(a)(1) A health insurance plan shall provide coverage for outpatient contraceptive services including sterilizations, and shall provide coverage for the purchase of all prescription contraceptives and prescription contraceptive devices approved by the U.S. Food and Drug Administration (FDA), except that a health insurance plan that does not provide coverage of prescription drugs is not required to provide coverage of prescription contraceptives and prescription contraceptive devices.

(2) A health insurance plan providing coverage required under this section shall not establish any rate, term, or condition that places a greater financial burden on a covered individual for access to contraceptive services, prescription contraceptives, and prescription contraceptive devices than for access to treatment, prescriptions, or devices for any other health condition.

(b) A health insurance plan shall provide coverage without any deductible, coinsurance, co-payment, or other cost-sharing requirement for at least one drug, device, or other product within each method of contraception for women identified by the FDA and prescribed by a covered individual's health care professional.

(1) The coverage provided pursuant to this subsection shall include patient education and counseling by the covered individual's health care provider regarding the appropriate use of the contraceptive method prescribed.

(2)(A) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, a health insurance plan may provide coverage for more than one drug, device, or other product and may impose cost-sharing requirements as long as at least one drug, device, or other product for that method is available without cost sharing.

(B) If a covered individual's health care professional recommends a particular service or FDA-approved drug, device, or other product for the covered individual based on a determination of medical necessity, the health insurance plan shall defer to the health care professional's determination and judgment and shall provide coverage without cost sharing for the drug, device, or product prescribed by the health care professional for the covered individual.

(c) A health insurance plan shall provide coverage for voluntary sterilization procedures for men and women without any deductible,

coinsurance, co-payment, or other cost-sharing requirement, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

(d) A health insurance plan shall provide coverage without any deductible, coinsurance, co-payment, or other cost-sharing requirement for clinical services associated with providing the drugs, devices, products, and procedures covered under this section and related follow-up services, including management of side effects, counseling for continued adherence, and device insertion and removal.

(e)(1) A health insurance plan shall provide coverage for a supply of prescribed contraceptives intended to last over a 12-month duration, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider. The health insurance plan shall reimburse a health care provider or dispensing entity per unit for furnishing or dispensing a supply of contraceptives intended to last for 12 months.

(2) This subsection shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

(f) Benefits provided under this section shall be the same for individuals covered under the health insurance plan.

(g) The coverage requirements of this section shall apply to self-administered hormonal contraceptives prescribed for a covered individual by a pharmacist in accordance with 26 V.S.A. § 2023.

§ 4078. MIDWIFERY COVERAGE; HOME BIRTHS

(a) A health insurance plan providing maternity benefits shall also provide coverage for services rendered by a midwife licensed pursuant to 26 V.S.A. chapter 85 or an advanced practice registered nurse licensed pursuant to 26 V.S.A. chapter 28 who is certified as a nurse midwife for services within the licensed midwife's or certified nurse midwife's scope of practice and provided in a hospital or other health care facility or at home.

(b) Coverage for services provided by a licensed midwife or certified nurse midwife shall not be subject to any greater co-payment, deductible, or coinsurance than is applicable to any other similar benefits provided by the health insurance plan.

(c) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

§ 4079. ABORTION AND ABORTION-RELATED SERVICES

(a) As used in this section, "abortion" means any medical treatment intended to induce the termination of, or to terminate, a clinically diagnosable pregnancy except for the purpose of producing a live birth.

(b)(1) A health insurance plan shall provide coverage for abortion and abortion-related care.

(2) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

(c) The coverage required by this section shall not be subject to any co-payment, deductible, coinsurance, or other cost-sharing requirement or additional charge, except:

(1) to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223; and

(2) for coverage provided by Medicaid.

§ 4080. ANESTHESIA FOR CERTAIN DENTAL PROCEDURES

(a) As used in this section:

(1) "Ambulatory surgical center" has the same meaning as in 18 V.S.A. § 2141.

(2) "Anesthesiologist" means a physician who is licensed under 26 V.S.A. chapter 23 or 33 and who either:

(A) has completed a residency in anesthesiology approved by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology or their predecessors or successors; or

(B) is credentialed by a hospital to practice anesthesiology and engages in the practice of anesthesiology at that hospital full-time.

(3) "Certified registered nurse anesthetist" means an advanced practice registered nurse licensed by the Vermont Board of Nursing to practice as a certified registered nurse anesthetist.

(4) "Licensed mental health professional" means a licensed physician, psychologist, psychoanalyst, social worker, marriage and family therapist, clinical mental health counselor, or nurse with professional training, experience, and demonstrated competence in the treatment of a mental condition or psychiatric disability.

(b) A health insurance plan shall provide coverage for the hospital or ambulatory surgical center charges and administration of general anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist for dental procedures performed on a covered individual who is:

(1) a child seven years of age or younger who is determined by a dentist licensed pursuant to 26 V.S.A. chapter 13 to be unable to receive needed dental treatment in an outpatient setting, where the provider treating the covered individual certifies that due to the covered individual's age and the covered individual's condition or problem, hospitalization or general anesthesia in a hospital or ambulatory surgical center is required in order to perform significantly complex dental procedures safely and effectively;

(2) a child 12 years of age or younger with documented phobias or a documented mental condition or psychiatric disability, as determined by a physician licensed pursuant to 26 V.S.A. chapter 23 or 33 or by a licensed mental health professional, whose dental needs are sufficiently complex and urgent that delaying or deferring treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity; for whom a successful result cannot be expected from dental care provided under local anesthesia; and for whom a superior result can be expected from dental care provided under general anesthesia; or

(3) a person who has exceptional medical circumstances or a developmental disability, as determined by a physician licensed pursuant to 26 V.S.A. chapter 23 or 33, that place the person at serious risk.

(c) A health insurance plan may require prior authorization for general anesthesia and associated hospital or ambulatory surgical center charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(d) A health insurance plan may restrict coverage for general anesthesia and associated hospital or ambulatory surgical center charges to dental care that is provided by:

(1) a fully accredited specialist in pediatric dentistry;

(2) a fully accredited specialist in oral and maxillofacial surgery; and

(3) a dentist to whom hospital privileges have been granted.

(e) The provisions of this section shall not be construed to require a health insurance plan to provide coverage for the dental procedure or other dental care for which general anesthesia is provided.

(f) The provisions of this section shall not be construed to prevent or require reimbursement by a health insurance plan for the provision of general anesthesia and associated facility charges to a dentist holding a general anesthesia endorsement issued by the Vermont Board of Dental Examiners if the dentist has provided services pursuant to this section on an outpatient basis in the dentist's own office and the dentist is in compliance with the endorsement's terms and conditions.

§ 4081. TOBACCO CESSATION

(a) As used in this section, "tobacco cessation medication" means all therapies approved by the U.S. Food and Drug Administration for use in tobacco cessation.

(b) A health insurance plan shall provide coverage of at least one three-month supply per year of tobacco cessation medication, including over-the-counter medication, if prescribed by a licensed health care professional for an individual covered under the plan. A health insurance plan may require the individual to pay the plan's applicable prescription drug co-payment for the tobacco cessation medication.

(c) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

§ 4082. EARLY CHILDHOOD DEVELOPMENT DISORDERS

(a) As used in this section:

(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) "Autism spectrum disorders" means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger's disorder.

(3) "Behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis, that are:

(A) necessary to develop skills and abilities for the maximum reduction of physical or mental disability and for restoration of an individual to the individual's best functional level, or to ensure that an individual 21 years of age achieves proper growth and development; and

(B) provided or supervised by a nationally board-certified behavior analyst or by a licensed health care professional, provided the services performed are within the health care professional's scope of practice and certifications.

(4) "Diagnosis of early childhood developmental disorders" means medically necessary assessments, evaluations, or tests to determine whether an individual has an early childhood developmental delay, including an autism spectrum disorder.

(5) "Early childhood developmental disorder" means a childhood mental or physical impairment or combination of mental and physical impairments that results in functional limitations in major life activities, accompanied by a diagnosis defined by the DSM or the International Classification of Diseases (ICD), as periodically revised. The term includes autism spectrum disorders but does not include a learning disability.

(6) "Evidence-based" has the same meaning as in 18 V.S.A. § 4621.

(7) "Medically necessary" describes health care services that are appropriate in terms of type, amount, frequency, level, setting, and duration to the individual's diagnosis or condition; are informed by generally accepted medical or scientific evidence; and are consistent with generally accepted practice parameters. Such services shall be informed by the unique needs of each individual and each presenting situation and shall include a determination

that a service is needed to achieve proper growth and development or to prevent the onset or worsening of a health condition.

(8) "Natural environment" means a home or child care setting.

(9) "Pharmacy care" means medications prescribed by a licensed health care professional and any health-related services deemed medically necessary to determine the need for or effectiveness of a medication.

(10) "Psychiatric care" means direct or consultative services provided by a licensed physician certified in psychiatry by the American Board of Medical Specialties.

(11) "Psychological care" means direct or consultative services provided by a psychologist licensed pursuant to 26 V.S.A. chapter 55.

(12) "Therapeutic care" means services provided by licensed or certified speech language pathologists, occupational therapists, or physical therapists.

(13) "Treatment for early developmental disorders" means evidence-based care and related equipment prescribed or ordered for an individual by a licensed health care professional or a licensed psychologist who determines the care to be medically necessary, including:

(A) behavioral health treatment;

(B) pharmacy care;

(C) psychiatric care;

(D) psychological care; and

(E) therapeutic care.

(b)(1) A health insurance plan shall provide coverage for the evidence-based diagnosis and treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches 21 years of age.

(2) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State. Coverage provided pursuant to this section by Medicaid or any other public health care assistance program shall comply with all federal requirements imposed by the Centers for Medicare and Medicaid Services.

(3) A major medical insurance plan is not required to provide any benefits required by this section that exceed the essential health benefits specified under Section 1302(b) of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended.

(c) The amount, frequency, and duration of treatment described in this section shall be based on medical necessity and may be subject to a prior authorization requirement under the health insurance plan.

(d) A health insurance plan shall not impose greater coinsurance, co-payment, deductible, or other cost-sharing requirements for coverage of the diagnosis or treatment of early childhood developmental disorders than apply

to the diagnosis and treatment of any other physical or mental condition under the plan.

(e)(1) A health insurance plan shall provide coverage for applied behavior analysis when the services are provided or supervised by a licensed health care professional who is working within the scope of the health care professional's license or who is a nationally board-certified behavior analyst.

(2) A health insurance plan shall provide coverage for services under this section delivered in the natural environment when the services are furnished by a health care professional working within the scope of the health care professional's license or under the direct supervision of a licensed health care professional or, for applied behavior analysis, by or under the supervision of a nationally board-certified behavior analyst.

(f) Except for inpatient services, if an individual is receiving treatment for an early developmental delay, the health insurance plan may require treatment plan reviews based on the needs of the covered individual, consistent with reviews for other diagnostic areas and with rules established by the Department of Financial Regulation. A health insurance plan may review the treatment plan for children under eight years of age not more frequently than once every six months.

(g) Nothing in this section shall be construed to affect any obligation to provide services to an individual under an individualized family service plan,

individualized education program, or individualized service plan. A health insurance plan shall not reimburse services provided under 16 V.S.A. § 2959a.

(h) It is the intent of the General Assembly that the Department of Financial Regulation facilitate and encourage health insurance plans to bundle co-payments accrued by beneficiaries receiving services under this section to the extent possible.

§ 4083. SERVICES FOR VICTIMS OF SEXUAL ASSAULT

(a) As used in this section, "sexual assault examination" means either or both of the following:

(1) a physical examination of the patient, documentation of biological and physical findings, and collection of evidence; and

(2) treatment of the patient's injuries; providing care for sexually transmitted infections; assessing pregnancy risk; discussing treatment options, including reproductive health services, screening for the human immunodeficiency virus, and prophylactic treatment when appropriate; and providing instructions and referrals for follow-up care.

(b) A health insurance plan shall not impose any co-payment or coinsurance or, to the extent permitted under federal law, deductible or other cost-sharing requirement for the sexual assault examination of a victim of alleged sexual assault for health care services associated with specific procedure codes identified in a memorandum of understanding between the health insurer and the Vermont Center for Crime Victim Services.

§ 4084. PHYSICAL THERAPY CO-PAYMENTS FOR CERTAIN PLANS

For silver- and bronze-level qualified health benefit plans and any reflective health benefit plans offered at the silver or bronze level pursuant to 33 V.S.A. chapter 18, subchapter 1, health care services provided by a licensed physical therapist may be subject to a co-payment requirement, provided that any required co-payment amount shall be between 125 and 150 percent of the amount of the co-payment applicable to care and services provided by a primary care provider under the plan.

Subchapter 10. Prescription Drug Coverage

§ 4091. DEFINITIONS

As used in this subchapter:

(1) "Direct solicitation" means direct contact, including telephone, computer, email, instant messaging, or in-person contact, by a pharmacy provider or its agent to an individual covered under a health insurance plan without the covered individual's consent for the purpose of marketing the pharmacy provider's services.

(2) "Health care professional" means an individual licensed to practice medicine under 26 V.S.A. chapter 23 or 33, an individual licensed as a physician assistant under 26 V.S.A. chapter 31, or an individual licensed as an advanced practice registered nurse under 26 V.S.A. chapter 28.

(3) "Health insurance plan" has the same meaning as in section 4011 of this chapter and includes prescription drug benefits managed by a health insurer or by a pharmacy benefit manager on behalf of a health insurer.

(4) "Interchangeable biological products" has the same meaning as in 18 V.S.A. § 4601.

(5) "Out-of-pocket expenditure" means a co-payment, coinsurance, deductible, or other cost-sharing mechanism.

(6) "Pharmacy benefit manager" means an entity that performs pharmacy benefit management. "Pharmacy benefit management" means an arrangement for the procurement of prescription drugs at negotiated dispensing rates, the administration or management of prescription drug benefits provided by a health insurance plan for the benefit of beneficiaries, or any of the following services provided with regard to the administration of pharmacy benefits:

(A) mail service pharmacy;

(B) claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;

(C) clinical formulary development and management services;

(D) rebate contracting and administration;

(E) certain patient compliance, therapeutic intervention, and generic substitution programs; and

(F) disease management programs.

(7) "Pharmacy benefit manager affiliate" means a pharmacy or pharmacist that, directly or indirectly, through one or more intermediaries, is owned or controlled by, or is under common ownership or control with, a pharmacy benefit manager.

(8) "Prescription drug" or "drug" has the same meaning as "prescription drug" in 26 V.S.A. § 2022 and includes:

(A) biological products, as defined in 18 V.S.A. § 4601;

(B) medications used to treat complex, chronic conditions, including medications that require administration, infusion, or injection by a health care professional;

(C) medications for which the manufacturer or the U.S. Food and Drug Administration requires exclusive, restricted, or limited distribution; and

(D) medications with specialized handling, storage, or inventory reporting requirements.

(9) "Prescription insulin medication" means a prescription drug that contains insulin and is used to treat diabetes.

(10) "Step therapy" means protocols that establish the specific sequence in which prescription drugs for a specific medical condition are to be prescribed.

§ 4092. PRESCRIPTION DRUG COVERAGE

(a) A health insurance plan shall not include an annual dollar limit on prescription drug benefits.

(b) A health insurance plan shall limit a covered individual's out-of-pocket expenditures for all prescription drugs to not more for self-only and family coverage per year than the minimum dollar amounts in effect under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively.

(c)(1) For prescription drug benefits offered in conjunction with a high-deductible health plan (HDHP), the plan shall not provide prescription drug benefits until the expenditures applicable to the deductible under the HDHP have met the amount of the minimum annual deductibles in effect for self-only and family coverage under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, except that a plan may offer first-dollar prescription drug benefits to the extent permitted under federal law.

(2) Once the applicable expenditure amount set forth in subdivision (1) of this subsection has been met under the HDHP, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in subsection (b) of this section.

(d)(1) A health insurance plan that uses step-therapy protocols shall:

(A) not require failure, including discontinuation due to lack of efficacy or effectiveness, diminished effect, or an adverse event, on the same drug on more than one occasion for covered individuals who are continuously

enrolled in a plan offered by the health insurer or its pharmacy benefit manager; and

(B) grant an exception to its step-therapy protocols upon request of a covered individual or the covered individual's treating health care professional under the same time parameters as set forth for prior authorization requests in 18 V.S.A. § 9418b(g)(4) if any one or more of the following conditions apply:

(i) the prescription drug required under the step-therapy protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm to the covered individual;

(ii) the prescription drug required under the step-therapy protocol is expected to be ineffective based on the covered individual's known clinical history, condition, and prescription drug regimen;

(iii) the covered individual has already tried the prescription drugs on the protocol, or other prescription drugs in the same pharmacologic class or with the same mechanism of action, which have been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, regardless of whether the covered individual was covered at the time on a plan offered by the current insurer or its pharmacy benefit manager;

(iv) the covered individual is stable on a prescription drug selected by the covered individual's treating health care professional for the medical condition under consideration; or

(v) the step-therapy protocol or a prescription drug required under the protocol is not in the covered individual's best interests because it will:

(I) pose a barrier to adherence;

(II) likely worsen a comorbid condition; or

(III) likely decrease the covered individual's ability to achieve or maintain reasonable functional ability.

(2) Nothing in this subsection shall be construed to prohibit the use of tiered co-payments for covered individuals not subject to a step-therapy protocol.

(3) Notwithstanding any provision of subdivision (1) of this subsection to the contrary, a health insurance shall not utilize a step-therapy, "fail first," or other protocol that requires documented trials of a prescription drug, including a trial documented through a "MedWatch" (FDA Form 3500), before approving a prescription for the treatment of substance use disorder.

(e)(1) A health insurance plan shall not require, as a condition of coverage, use of drugs not indicated by the U.S. Food and Drug Administration for the condition diagnosed and being treated under the supervision of a health care professional.

(2) Nothing in this subsection shall be construed to prevent a health care professional from prescribing a prescription drug for off-label use.

(f) A health insurance plan shall apply the same cost-sharing requirements to interchangeable biological products as apply to generic drugs under the plan.

(g)(1) A health insurance plan shall limit a covered individual's total out-of-pocket responsibility for prescription insulin drugs to not more than $100.00 per 30-day supply, regardless of the amount, type, or number of insulin drugs prescribed for the covered individual.

(2) The $100.00 monthly limit on out-of-pocket spending for prescription insulin drugs set forth in subdivision (1) of this subsection shall apply regardless of whether the covered individual has satisfied any applicable deductible requirement under the health insurance plan.

(h) A health insurance plan shall cover, without requiring prior authorization, at least one readily available asthma controller drug from each class of drug and mode of administration. As used in this subsection, "readily available" means that the medication is not listed on a national drug shortage list, including lists maintained by the U.S. Food and Drug Administration and by the American Society of Health-System Pharmacists.

(i) On a periodic basis but not less than once per calendar year, each health insurer shall notify all individuals covered under its health insurance plans of any changes in pharmaceutical coverage and provide access to the preferred drug list maintained by the health insurer or its pharmacy benefit manager.

(j) The Department of Financial Regulation shall enforce this section and may adopt rules as necessary to carry out the purposes of this section.

(k) A health insurance plan shall provide coverage for prescription drugs purchased in Canada and used in Canada or reimported legally on the same

benefit terms and conditions as prescription drugs purchased in this country. For drugs purchased by mail or through the internet, the plan may require accreditation by the Internet and Mailorder Pharmacy Accreditation Commission (IMPAC/tm) or similar organization.

§ 4093. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS

(a) A health insurer or pharmacy benefit manager doing business in Vermont shall permit a retail pharmacist licensed under 26 V.S.A. chapter 36 to fill prescriptions for all prescription drugs in the same manner and at the same level of reimbursement as they are filled by any other pharmacist or pharmacy, including a mail-order pharmacy or a pharmacy benefit manager affiliate, with respect to the quantity of drugs or days' supply of drugs dispensed under each prescription.

(b) Notwithstanding any provision of a health insurance plan to the contrary, if a health insurance plan provides for payment or reimbursement that is within the lawful scope of practice of a pharmacist, the health insurer may provide payment or reimbursement for the service when the service is provided by a pharmacist.

(c)(1) A health insurer or pharmacy benefit manager shall permit a participating network pharmacy to perform all pharmacy services within the lawful scope of the profession of pharmacy as set forth in 26 V.S.A. chapter 36.

(2) A health insurer or pharmacy benefit manager shall not do any of the following:

(A) Require a covered individual, as a condition of payment or reimbursement, to purchase pharmacist services, including prescription drugs, exclusively through a mail-order pharmacy or a pharmacy benefit manager affiliate.

(B) Offer or implement plan designs that require a covered individual to use a mail-order pharmacy or a pharmacy benefit manager affiliate.

(C) Order a covered individual, orally or in writing, including through online messaging, to use a mail-order pharmacy or a pharmacy benefit manager affiliate.

(D) Establish network requirements that are more restrictive than or inconsistent with State or federal law, rules adopted by the Board of Pharmacy, or guidance provided by the Board of Pharmacy or by drug manufacturers that operate to limit or prohibit a pharmacy or pharmacist from dispensing or prescribing drugs.

(E) Offer or implement plan designs that increase plan or patient costs if the covered individual chooses not to use a mail-order pharmacy or a pharmacy benefit manager affiliate. The prohibition in this subdivision (E) includes requiring a covered individual to pay the full cost for a prescription drug when the covered individual chooses not to use a mail-order pharmacy or a pharmacy benefit manager affiliate.

(F)(i) Exclude any amount paid by or on behalf of a covered individual, including any third-party payment, financial assistance, discount, coupon, or other reduction, when calculating a covered individual's contribution toward:

(I) the out-of-pocket limits for prescription drug costs under section 4092 of this title;

(II) the covered individual's deductible, if any; or

(III) to the extent not inconsistent with Sec. 2707 of the Public Health Service Act, 42 U.S.C. § 300gg-6, the annual out-of-pocket maximums applicable to the covered individual's health benefit plan.

(ii) The provisions of subdivision (i) of this subdivision (F) relating to a third-party payment, financial assistance, discount, coupon, or other reduction in out-of-pocket expenses made on behalf of a covered individual shall only apply to a prescription drug:

(I) for which there is no generic drug or interchangeable biological product, as those terms are defined in 18 V.S.A. § 4601; or

(II) for which there is a generic drug or interchangeable biological product, as those terms are defined in 18 V.S.A. § 4601, but for which the covered individual has obtained access through prior authorization, a step therapy protocol, or the pharmacy benefit manager's or health insurer's exceptions and appeals process.

(iii) The provisions of subdivision (i) of this subdivision (F) shall apply to a high-deductible health plan only to the extent that it would not disqualify the plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

(3) A health insurer or pharmacy benefit manager shall not, by contract, written policy, or written procedure, require that a pharmacy designated by the health insurer or pharmacy benefit manager dispense a medication directly to a covered individual with the expectation or intention that the covered individual will transport the medication to a health care setting for administration by a health care professional.

(4) A health insurer or pharmacy benefit manager shall not, by contract, written policy, or written procedure, require that a pharmacy designated by the health insurer or pharmacy benefit manager dispense a medication directly to a health care setting for a health care professional to administer to a covered individual.

(5) A health insurer or pharmacy benefit manager shall adhere to the definitions of prescription drugs and the requirements and guidance regarding the pharmacy profession established by State and federal law and the Vermont Board of Pharmacy and shall not establish classifications of or distinctions between prescription drugs, impose penalties on prescription drug claims, attempt to dictate the behavior of pharmacies or pharmacists, or place restrictions on pharmacies or pharmacists that are more restrictive than or

inconsistent with State or federal law or with rules adopted or guidance provided by the Board of Pharmacy.

(6) A pharmacy benefit manager or licensed pharmacy shall not make a direct solicitation to an individual covered by a health insurance plan unless one or more of the following applies:

(A) the covered individual has given written permission to the supplier or the ordering health care professional to contact the covered individual regarding the furnishing of a prescription item that is to be rented or purchased;

(B) the supplier has furnished a prescription item to the covered individual and is contacting the covered individual to coordinate delivery of the item; or

(C) if the contact relates to the furnishing of a prescription item other than a prescription item already furnished to the covered individual, the supplier has furnished at least one prescription item to the covered individual within the 15-month period preceding the date on which the supplier attempts to make the contact.

(d) A health insurer or pharmacy benefit manager shall not alter a covered individual's prescription drug order or the pharmacy chosen by the covered individual without the covered individual's consent; provided, however, that nothing in this subsection shall be construed to affect the duty of a pharmacist

to substitute a lower-cost drug or biological product in accordance with the provisions of 18 V.S.A. § 4605.

(e) All of the provisions of this section except subsection (c) shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

Subchapter 11. Prevention and Treatment of Cancer

§ 4095a. COLORECTAL CANCER SCREENING

(a) As used in this section, "colonoscopy" means a procedure that enables a health care professional to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps or biopsy, or both.

(b) A health insurance plan shall provide coverage for colorectal cancer screening, including:

(1) for a covered individual who is not at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests in accordance with the most recently published recommendations established by the U.S. Preventive Services Task Force for average-risk individuals; and

(2) for a covered individual who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating health care professional.

(c) For the purposes of subdivision (b)(2) of this section, an individual is at high risk for colorectal cancer if the individual has:

(1) a family medical history of colorectal cancer or a genetic syndrome predisposing the individual to colorectal cancer;

(2) a prior occurrence of colorectal cancer or precursor polyps;

(3) a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or

(4) other predisposing factors as determined by the individual's treating health care professional.

(d) Colorectal cancer screening services performed under contract with the insurer shall not be subject to any co-payment, deductible, coinsurance, or other cost-sharing requirement. In addition, a covered individual shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include one or more of the following:

(1) removal of tissue or other matter;

(2) laboratory services;

(3) health care professional services;

(4) facility use; and

(5) anesthesia.

§ 4095b. MAMMOGRAPHY AND OTHER BREAST IMAGING SERVICES

(a)(1) A health insurance plan shall provide coverage for screening mammography and for other medically necessary breast imaging services upon

recommendation of a health care professional as needed to detect the presence of breast cancer and other abnormalities of the breast or breast tissue. In addition, a health insurance plan shall provide coverage for screening by ultrasound or another appropriate imaging service for a covered individual for whom the results of a screening mammogram were inconclusive or who has dense breast tissue, or both.

(2) Benefits provided shall cover the full cost of the mammography, ultrasound, and other breast imaging services and shall not be subject to any co-payment, deductible, coinsurance, or other cost-sharing requirement or additional charge, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

(b) This section shall apply only to procedures conducted by test facilities accredited by the American College of Radiologists.

(c) As used in this section:

(1) "Mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and digital detector. The term includes breast tomosynthesis.

(2) "Other breast imaging services" means diagnostic mammography, ultrasound, and magnetic resonance imaging services that enable health care

professionals to detect the presence or absence of breast cancer and other abnormalities affecting the breast or breast tissue.

(3) "Screening" includes the mammography or ultrasound test procedure and a qualified health care professional's interpretation of the results of the procedure, including additional views and interpretation as needed.

§ 4095c. PROSTATE CANCER SCREENINGS

A health insurance plan shall provide coverage for prostate cancer screenings consistent with the recommendations of the Centers for Disease Control and Prevention or upon recommendation of the covered individual's health care professional. Benefits provided shall be at least as favorable as coverage for other cancer screening procedures and subject to the same dollar limits, deductibles, and coinsurance factors within the provisions of the policy.

§ 4095d. CHEMOTHERAPY TREATMENT AND ORAL ANTICANCER MEDICATIONS

(a) A health insurance plan shall provide coverage for medically necessary growth cell stimulating factor injections taken as part of a prescribed chemotherapy regimen.

(b) A health insurance plan shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is not less favorable on a financial basis than intravenously administered or injected anticancer medications covered under the covered individual's plan.

§ 4095e. CLINICAL TRIALS FOR CANCER PATIENTS

(a) The Commissioner shall, after notice and hearing, adopt rules requiring that all health insurance plans issued in this State provide coverage for routine costs for covered individuals who participate in cancer clinical trials.

(1) Any rules adopted under this section shall be limited to the coverage of routine costs for covered individuals who participate in a cancer clinical trial.

(2) Any rules adopted under this section shall be restricted to approved cancer clinical trials conducted under the auspices of the following cancer care providers (cancer care providers): The University of Vermont Medical Center, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, and approved clinical trials administered by a hospital and its affiliated, qualified cancer care providers.

(3) For participation in clinical trials located outside Vermont, coverage under this section shall be required only if the covered individual provides notice to the health insurance plan prior to participation in the clinical trial, and one or more of the following circumstances applies:

(A) no clinical trial is available at the Vermont or New Hampshire cancer care providers described in subdivision (2) of this subsection (a);

(B) the covered individual already has completed a clinical trial at one of the Vermont or New Hampshire cancer care providers described in subdivision (2) of this subsection (a) and the covered individual's cancer care

provider determines that a subsequent clinical trial related to the original diagnosis is available outside the health benefit plan's network and that participation in that clinical trial would be in the best interests of the covered individual, even if a comparable clinical trial is available at that time at one or both of the Vermont or New Hampshire cancer care providers described in subdivision (2) of this subsection (a); or

(C) the health insurance plan has already approved a referral of the covered individual to an out-of-network cancer care provider and an out-of-network clinical trial becomes available and the covered individual's cancer care provider determines participation in that clinical trial would be in the best interests of the covered individual, even if a comparable clinical trial is available at one or both of the Vermont or New Hampshire cancer care providers described in subdivision (2) of this subsection (a).

(4) If a covered individual participates in a clinical trial administered by a cancer care provider that is not in the health insurance plan's provider network, the health insurance plan may require that routine follow-up care be provided within the health insurance plan's network, unless the cancer care provider determines this would not be in the best interest of the covered individual.

(b) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

§ 4095f. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR CANCER

(a) As used in this section:

(1) "Medical or scientific evidence" means one or more of the following sources:

(A) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);

(C) medical journals recognized by the Secretary of the U.S. Department of Health and Human Services under Section 1861(t)(2) of the Social Security Act;

(D) the following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, and the United States Pharmacopoeia-Drug Information;

(E) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research

institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

(F) peer-reviewed abstracts accepted for presentation at major medical association meetings.

(2) "Medically accepted indication" includes any use of a drug that has been approved by the U.S. Food and Drug Administration and includes another use of the drug if that use is prescribed by the covered individual's health care professional and supported by medical or scientific evidence.

(3) "Off-label use" means the prescription and use of drugs for medically accepted indications other than those stated in the labeling approved by the U.S. Food and Drug Administration.

(b) A health insurance plan shall provide coverage for off-label use in cancer treatment in accordance with the following:

(1) A health insurance plan contract shall not exclude coverage for any drug used for the treatment of cancer on grounds that the drug has not been approved by the U.S. Food and Drug Administration, provided the use of the drug is a medically accepted indication for the treatment of cancer.

(2) Coverage of a drug required by this section also includes medically necessary services associated with the administration of the drug.

(3) This section shall not be construed to require coverage for a drug when the U.S. Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication.

(4) A drug use that is covered under subdivision (1) of this subsection shall not be denied coverage based on a "medical necessity" requirement except for a reason unrelated to the legal status of the drug use.

(5) A health insurance plan that provides coverage of a drug as required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles, and exclusions to the same extent these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this section.

(c) A determination by a health insurer that an off-label use of a prescription drug under this section is not a medically accepted indication supported by medical or scientific evidence is eligible for review under section 4063 of this title.

(d) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

Subchapter 12. Service Delivery and Treatment Modalities

§ 4098a. COVERAGE OF HEALTH CARE SERVICES DELIVERED THROUGH TELEMEDICINE AND BY STORE-AND-FORWARD MEANS

(a) As used in this section:

(1) "Distant site" means the location of the health care provider delivering services through telemedicine at the time the services are provided.

(2) "Health insurance plan" has the same meaning as in section 4011 of this title and also includes a stand-alone dental plan or policy or other dental insurance plan offered by a dental insurer.

(3) "Health care facility" has the same meaning as in 18 V.S.A. § 9402.

(4) "Health care provider" means a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services, including dental services, in this State to an individual during that individual's medical care, treatment, or confinement.

(5) "Originating site" means the location of the patient, whether or not accompanied by a health care provider, at the time services are provided by a health care provider through telemedicine, including a health care provider's office, a hospital, or a health care facility, or the patient's home or another nonmedical environment such as a school-based health center, a university-based health center, or the patient's workplace.

(6) "Store-and-forward" means an asynchronous transmission of medical information, such as one or more video clips, audio clips, still images, x-rays, magnetic resonance imaging scans, electrocardiograms, electroencephalograms, or laboratory results, sent over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 to be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty. In store-and-forward, the health care provider at the distant site reviews the medical information without the patient present in real time and communicates a care plan or treatment recommendation back to the patient or referring provider, or both.

(7) "Telemedicine" means the delivery of health care services, including dental services, such as diagnosis, consultation, or treatment, through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

(b)(1) A health insurance plan shall provide coverage for health care services and dental services delivered through telemedicine by a health care provider at a distant site to a covered individual at an originating site to the same extent that the plan would cover the services if they were provided through in-person consultation.

(2)(A) A health insurance plan shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through an in-person visit with the health care provider or through telemedicine.

(B) The provisions of subdivision (A) of this subdivision (2) shall not apply:

(i) to services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor to provide health care or dental services; or

(ii) in the event that a health insurer and health care provider enter into a value-based contract for health care services that include care delivered through telemedicine or by store-and-forward means.

(c) A health insurance plan may charge a deductible, co-payment, or coinsurance for a health care service or dental service provided through telemedicine as long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(d) A health insurance plan may limit coverage to health care providers in the plan's network. A health insurance plan shall not impose limitations on the number of telemedicine consultations a covered individual may receive that exceed limitations otherwise placed on in-person covered services.

(e) Nothing in this section shall be construed to prohibit a health insurance plan from providing coverage for only those services that are medically necessary and are clinically appropriate for delivery through telemedicine, subject to the terms and conditions of the covered individual's policy.

(f)(1) A health insurance plan shall reimburse for health care services and dental services delivered by store-and-forward means.

(2) A health insurance plan shall not impose more than one cost-sharing requirement on a covered individual for receipt of health care services or dental services delivered by store-and-forward means. If the services would require cost sharing under the terms of the covered individual's health insurance plan, the plan may impose the cost sharing requirement on the services of the originating site health care provider or of the distant site health care provider, but not both.

(g) A health insurance plan shall not construe a covered individual's receipt of services delivered through telemedicine or by store-and-forward means as limiting in any way the covered individual's ability to receive additional covered in-person services from the same or a different health care provider for diagnosis or treatment of the same condition.

(h) Nothing in this section shall be construed to require a health insurance plan to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(i) In order to facilitate the use of telemedicine in treating substance use disorder, when the originating site is a health care facility, health insurers and the Department of Vermont Health Access shall ensure that the health care provider at the distant site and the health care facility at the originating site are both reimbursed for the services rendered, unless the health care providers at both the distant and originating sites are employed by the same entity.

(j) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

§ 4098b. COVERAGE OF HEALTH CARE SERVICES DELIVERED BY AUDIO-ONLY TELEPHONE

(a) As used in this section, "health care provider" means a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services in this State to an individual during that individual's medical care, treatment, or confinement.

(b)(1) A health insurance plan shall provide coverage for all medically necessary, clinically appropriate health care services delivered remotely by audio-only telephone to the same extent that the plan would cover the services if they were provided through in-person consultation. Services covered under this subdivision shall include services that are covered when provided in the home by home health agencies.

(2)(A) A health insurance plan shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through an in-person visit with the health care provider or by audio-only telephone.

(B) The provisions of subdivision (A) of this subdivision (2) shall not apply in the event that a health insurer and health care provider enter into a value-based contract for health care services that include care delivered by audio-only telephone.

(c) A health insurance plan may charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered by audio-only telephone, provided that it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(d) A health insurance plan shall not require a health care provider to have an existing relationship with a covered individual in order to be reimbursed for health care services delivered by audio-only telephone.

(e) This section shall apply to Medicaid, to the extent permitted by the Centers for Medicare and Medicaid Services, and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

§ 4098c. COVERED SERVICES PROVIDED BY NATUROPATHIC PHYSICIANS

(a) A health insurance plan shall provide coverage for medically necessary health care services covered by the plan when provided by a naturopathic physician licensed in this State for treatment within the scope of practice described in 26 V.S.A. chapter 81 and shall recognize naturopathic physicians who practice primary care to be primary care physicians.

(b) Health care services provided by naturopathic physicians may be subject to reasonable deductibles, co-payment and coinsurance amounts, and fee or benefit limits consistent with those applicable to other primary care physicians under the plan, as well as practice parameters, cost-effectiveness and clinical efficacy standards, and utilization review consistent with any applicable rules published by the Department of Financial Regulation. Any amounts, limits, standards, and review shall not function to direct treatment in a manner unfairly discriminative against naturopathic care, and collectively shall be not more restrictive than those applicable under the same plan to care or services provided by other primary care physicians, but may allow for the management of the benefit consistent with variations in practice patterns and treatment modalities among different types of health care professionals.

(c) A health insurance plan may require that the naturopathic physician's services be provided by a licensed naturopathic physician under contract with the insurer or shall be covered in a manner consistent with out-of-network

provider reimbursement practices for primary care physicians; however, this shall not relieve a health insurance plan from compliance with the applicable network adequacy requirements adopted by the Commissioner by rule.

(d) Nothing contained in this section shall be construed as impeding or preventing either the provision or the coverage of health care services by licensed naturopathic physicians, within the lawful scope of naturopathic practice, in hospital facilities on a staff or employee basis.

(e) This section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

§ 4098d. COVERED SERVICES PROVIDED BY ATHLETIC TRAINERS

(a) To the extent a health insurance plan provides coverage for a particular type of health care service or for any particular medical condition that is within the scope of practice of athletic trainers, a licensed athletic trainer who acts within the scope of practice authorized by 26 V.S.A. chapter 83 shall not be denied reimbursement by the health insurance plan for those covered services if the health insurance plan would reimburse another health care professional for those services.

(b) Health care services provided by athletic trainers may be subject to reasonable deductibles, co-payment and co-insurance amounts, fee or benefit limits, practice parameters, and utilization review consistent with applicable rules adopted by the Department of Financial Regulation, provided that the

amounts, limits, and review shall not function to direct treatment in a manner unfairly discriminative against athletic trainer care, and collectively shall be not more restrictive than those applicable under the same policy for care or services provided by other health care professionals but allowing for the management of the benefit consistent with variations in practice patterns and treatment modalities among different types of health care professionals.

(c) A health insurer may require that the athletic trainer services be provided by a licensed athletic trainer under contract with the insurer.

(d) Nothing in this section shall be construed as impeding or preventing either the provision or coverage of health care services by licensed athletic trainers within the lawful scope of athletic trainer practice.

§ 4098e. CHOICE OF PROVIDERS FOR VISION CARE AND MEDICAL EYE CARE SERVICES

(a) As used in this section:

(1) "Covered services" means services and materials for which reimbursement from a vision care plan or other health insurance plan is provided by a member's or subscriber's plan contract, or for which a reimbursement would be available but for application of the deductible, co-payment, or coinsurance requirements under the member's or subscriber's health insurance plan.

(2) "Health insurance plan" has the same meaning as in section 4011 of this chapter and also includes vision care plans.

(3) "Materials" includes lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

(4) "Ophthalmologist" means a physician licensed pursuant to 26 V.S.A. chapter 23 or an osteopathic physician licensed pursuant to 26 V.S.A. chapter 33 who has had special training in the field of ophthalmology.

(5) "Optician" means a person licensed pursuant to 26 V.S.A. chapter 47.

(6) "Optometrist" means a person licensed pursuant to 26 V.S.A. chapter 30.

(7) "Vision care plan" means an integrated or stand-alone plan, policy, or contract providing vision benefits to enrollees with respect to covered services or covered materials, or both.

(b) To the extent a health insurance plan provides coverage for vision care or medical eye care services, it shall cover those services whether provided by a licensed optometrist or by a licensed ophthalmologist, provided the health care professional is acting within the health care professional's authorized scope of practice and participates in the plan's network.

(c) A health insurance plan shall impose no greater co-payment, coinsurance, or other cost-sharing amount for services when provided by an optometrist than for the same service when provided by an ophthalmologist.

(d) A health insurance plan shall provide to a licensed health care professional acting within the health care professional's scope of practice the same level of reimbursement or other compensation for providing vision care and medical eye care services that are within the lawful scope of practice of the professions of medicine, optometry, and osteopathy, regardless of whether the health care professional is an optometrist or an ophthalmologist.

(e)(1) A health insurer shall permit a licensed optometrist to participate in plans or contracts providing for vision care or medical eye care to the same extent as it does an ophthalmologist.

(2) A health insurer shall not require a licensed optometrist or ophthalmologist to provide discounted materials benefits or to participate as a provider in another health insurance or vision care plan or contract as a condition or requirement for the optometrist's or ophthalmologist's participation as a provider in any health insurance or vision care plan or contract.

(f)(1) An agreement between a health insurer and an optometrist or ophthalmologist for the provision of vision services to plan members or subscribers in connection with coverage under a stand-alone vision care plan or other health insurance plan shall not require that an optometrist or ophthalmologist provide services or materials at a fee limited or set by the plan or insurer unless the services or materials are reimbursed as covered services under the contract.

(2) An optometrist or ophthalmologist shall not charge more for services and materials that are noncovered services under a vision care plan or other health insurance plan than the optometrist's or ophthalmologist's usual and customary rate for those services and materials.

(3) Reimbursement paid by a vision care plan or other health insurance plan for covered services and materials shall be reasonable and shall not provide nominal reimbursement in order to claim that services and materials are covered services.

(4)(A) A vision care plan or other health insurance plan shall not restrict or otherwise limit, directly or indirectly, an optometrist's, ophthalmologist's, or independent optician's choice of or relationship with sources and suppliers of products, services, or materials or use of optical laboratories if the optometrist, ophthalmologist, or optician determines that the source, supplier, or laboratory that the optometrist, ophthalmologist, or optician has selected offers the products, services, or materials in a manner that is more beneficial to the consumer, including with respect to cost, quality, timing, or selection, than the source, supplier, or laboratory selected by the vision care plan or other health insurance plan. The plan shall not impose any penalty or fee on an optometrist, ophthalmologist, or independent optician for using any supplier, optical laboratory, product, service, or material.

(B) The optometrist, ophthalmologist, or optician shall notify the consumer of any additional costs the consumer may incur as the result of

procuring the products, services, or materials from the source, supplier, or laboratory selected by the optometrist, ophthalmologist, or optician instead of from the source, supplier, or laboratory selected by the vision care plan or other health insurance plan.

(C) Nothing in this subdivision (4) shall be construed to prevent a vision care plan or other health insurance plan from informing its policyholders of the benefits available under the plan or from conducting an audit of an optometrist's, ophthalmologist's, or optician's use of alternative sources, suppliers, or laboratories.

(D) The provisions of this subdivision (4) shall not apply to Medicaid.

(g)(1) Except as otherwise specified in subdivision (f)(4), this section shall apply to Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State.

(2) The Department of Financial Regulation shall enforce the provisions of this section as they relate to health insurance plans and vision care plans other than Medicaid.

* * * Conforming Revisions * * *

Sec. 3. 1 V.S.A. § 317(c) is amended to read:

(c) The following public records are exempt from public inspection and copying:

* * *

(28) Records of, and internal materials prepared for, independent external reviews of health care service decisions pursuant to ~~8 V.S.A. § 4089f~~ 8 V.S.A. § 4063 and of mental health care service decisions pursuant to ~~8 V.S.A. § 4089a~~ 8 V.S.A. § 4064.

* * *

Sec. 4. 8 V.S.A. § 4512(b) is amended to read:

(b) Subject to the approval of the Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, a hospital service corporation may establish, maintain, and operate a medical service plan as defined in section 4583 of this title. The Commissioner or the Board may refuse approval if the Commissioner or the Board finds that the rates submitted are excessive, inadequate, or unfairly discriminatory, fail to protect the hospital service corporation's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section ~~4062~~ 4026 of this title. The contracts of a hospital service corporation that operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

Sec. 5. 8 V.S.A. § 4515a is amended to read:

§ 4515a. FORM AND RATE FILING; FILING FEES

Every contract or certificate form, or amendment thereof, including the rates proposed to be charged by the corporation, shall be filed with the Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, for the Commissioner's or the Board's approval prior to issuance or use. Prior to approval, there shall be a public comment period pursuant to section ~~4062~~ 4026 of this title. In addition, each such filing shall be accompanied by payment to the Commissioner or the Board, as appropriate, of a nonrefundable fee of $150.00 and the plain language summary of rate increases pursuant to section ~~4062~~ 4026 of this title.

Sec. 6. 8 V.S.A. § 4516 is amended to read:

§ 4516. ANNUAL REPORT TO COMMISSIONER

Annually, on or before March 1, a hospital service corporation shall file with the Commissioner of Financial Regulation a statement sworn to by the president and treasurer of the corporation showing its condition on December 31. The statement shall be in such form and contain such matters as the Commissioner shall prescribe. To qualify for the tax exemption set forth in section 4518 of this title, the statement shall include a certification that the hospital service corporation operates on a nonprofit basis for the purpose of providing an adequate hospital service plan to individuals of the State, both groups and nongroups, without discrimination based on age, gender,

geographic area, industry, and medical history, except as allowed by ~~subdivisions 4080g(b)(7)(B)(ii) and 4080g(c)(8)(B)(ii) of this title and by~~ 33 V.S.A. § 1811(f)(2)(B).

Sec. 7. 8 V.S.A. § 4587 is amended to read:

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation that has received a permit from the Commissioner of Financial Regulation under section 4584 of this title shall not thereafter issue a contract to a subscriber or charge a rate that is different from copies of the contracts and rates originally filed with and approved by the Commissioner at the time the permit was issued to the medical service corporation, until the medical service corporation has filed copies of its proposed contracts and rates and they have been approved by the Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate. Prior to approval, there shall be a public comment period pursuant to section ~~4062~~ 4026 of this title. Each such filing of a contract or ~~the~~ rate ~~therefor~~ shall be accompanied by payment to the Commissioner or the Board, as appropriate, of a nonrefundable fee of $150.00. A medical service corporation shall file a plain language summary of rate increases pursuant to section ~~4062~~ 4026 of this title.

Sec. 8. 8 V.S.A. § 4588 is amended to read:

§ 4588. ANNUAL REPORT TO COMMISSIONER

Annually, on or before March 1, a medical service corporation shall file with the Commissioner of Financial Regulation a statement sworn to by the president and treasurer of the corporation showing its condition on December 31, which shall be in such form and contain such matters as the Commissioner shall prescribe. To qualify for the tax exemption set forth in section 4590 of this title, the statement shall include a certification that the medical service corporation operates on a nonprofit basis for the purpose of providing an adequate medical service plan to individuals of the State, both groups and nongroups, without discrimination based on age, gender, geographic area, industry, and medical history, except as allowed by ~~subdivisions 4080g(b)(7)(B)(ii) and 4080g(c)(8)(B)(ii) of this title and by~~ 33 V.S.A. § 1811(f)(2)(B).

Sec. 9. 8 V.S.A. § 4724(7)(E) is amended to read:

(E) Making or permitting unfair discrimination between married couples and parties to a civil union as defined under 15 V.S.A. § 1201, with regard to the offering of insurance benefits to a couple, a spouse, a party to a civil union, or their family. The Commissioner shall adopt rules necessary to carry out the purposes of this subdivision. The rules shall ensure that insurance contracts and policies offered to married couples, spouses, and families are also made available to parties to a civil union and their families.

The Commissioner may adopt by order standards and a process to bring the forms currently on file and approved by the Department into compliance with Vermont law. The standards and process may differ from the provisions contained in chapter 101, subchapter 6, and sections ~~4062~~ 4026, 4201, 4515a, 4587, 4685, 4687, 4688, 4985, 5104, and 8005 of this title where, in the Commissioner's opinion, the provisions regarding filing and approval of forms are not desirable or necessary to effectuate the purposes of this section.

Sec. 10. 8 V.S.A. § 5104(a) is amended to read:

(a)(1) A health maintenance organization that has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections ~~4062 and 4062a~~ 4026 and 4027 of this title. This requirement shall include the filing of administrative retentions for any business in which the organization acts as a third party administrator or in any other administrative processing capacity. The Commissioner or the Green Mountain Care Board, as appropriate, may request and shall receive any information that the Commissioner or the Board deems necessary to evaluate the filing. In addition to any other information requested, the Commissioner or the Board shall require the filing of information on costs for providing services to the organization's Vermont members affected by the policy form or rate, including Vermont claims experience, and administrative and overhead costs allocated to the service of Vermont members. Prior to approval, there shall be a public comment period

pursuant to section ~~4062~~ 4026 of this title. A health maintenance organization shall file a summary of rate filings pursuant to section ~~4062~~ 4026 of this title.

(2) The Commissioner or the Board shall refuse to approve the form of evidence of coverage, filing, or rate if it contains any provision that is unjust, unfair, inequitable, misleading, or contrary to the law of the State or plan of operation, or if the rates are excessive, inadequate, or unfairly discriminatory, fail to protect the organization's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section ~~4062~~ 4026 of this title. No evidence of coverage shall be offered to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

Sec. 11. 8 V.S.A. § 5115 is amended to read:

§ 5115. DUTY OF NONPROFIT HEALTH MAINTENANCE ORGANIZATIONS

Any nonprofit health maintenance organization subject to this chapter shall offer nongroup plans to individuals in accordance with 33 V.S.A. § 1811 without discrimination based on age, gender, industry, and medical history, except as allowed by ~~subdivisions 4080g(b)(7)(B)(ii) and 4080g(c)(8)(B)(ii) of this title and by~~ 33 V.S.A. § 1811(f)(2)(B).

Sec. 12. 8 V.S.A. § 8083 is amended to read:

§ 8083. EXTRATERRITORIAL JURISDICTION

No group long-term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in subdivision 8082(4)(D) of this title, unless this State or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this State has made a determination that such requirements have been met. All other jurisdiction shall be pursuant to section ~~4062~~ 4026 of this title.

Sec. 13. 8 V.S.A. § 8094(e) is amended to read:

(e) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by sections 3731 and ~~4065~~ 4029 of this title. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Sec. 14. 18 V.S.A. § 701 is amended to read:

§ 701. DEFINITIONS

As used in this chapter:

* * *

(8) "Health ~~benefit~~ insurance plan" ~~shall have~~ has the same meaning as ~~health~~ major medical insurance plan in ~~8 V.S.A. § 4088h~~ 8 V.S.A. § 4011.

* * *

Sec. 15. 18 V.S.A. § 706 is amended to read:

§ 706. HEALTH INSURER PARTICIPATION

(a) As ~~provided for in 8 V.S.A. § 4088h~~ set forth in 8 V.S.A. § 4025, health insurance plans shall be consistent with the Blueprint for Health as determined by the Commissioner of Financial Regulation.

(b) Health insurers shall participate in the Blueprint for Health as a condition of doing business in this State as provided for in this section and in ~~8 V.S.A. § 4088h~~ 8 V.S.A. § 4025. ~~Under 8 V.S.A. § 4088h, the Commissioner of Financial Regulation may exclude or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited benefit coverage in the Blueprint for Health. Health insurers shall be exempt from participation if the insurer only offers benefit plans that are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.~~

* * *

Sec. 16. 18 V.S.A. § 4750 is amended to read:

§ 4750. DEFINITIONS

As used in this chapter:

(1) "Health insurance plan" has the same meaning as in ~~8 V.S.A. § 4089b~~ 8 V.S.A. § 4011.

* * *

Sec. 17. 18 V.S.A. § 9361(a) is amended to read:

(a) As used in this section, "distant site," "health care provider," "originating site," ~~"store and forward,"~~ "store-and-forward," and "telemedicine" ~~shall~~ have the same meanings as in ~~8 V.S.A. § 4100k~~ 8 V.S.A. § 4089a.

Sec. 18. 18 V.S.A. § 9362(a) is amended to read:

(a) As used in this section~~, "health~~:

(1) "Health insurance plan" ~~and "health~~ has the same meaning as in 8 V.S.A. § 4011.

(2) "Health care provider" ~~have~~ has the same meaning as in ~~8 V.S.A. § 4100l and "telemedicine"~~ 8 V.S.A. § 4098b.

(3) "Telemedicine" has the same meaning as in ~~8 V.S.A. § 4100k~~ 8 V.S.A. § 4098a.

Sec. 19. 18 V.S.A. § 9375(b) is amended to read:

(b) The Board shall have the following duties:

* * *

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to ~~8 V.S.A. § 4062~~ 8 V.S.A. § 4026, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, protecting insurer solvency, and other issues at the discretion of the Board.

* * *

(12) ~~Review data regarding mental health and substance abuse treatment reported to the Department of Financial Regulation pursuant to 8 V.S.A. § 4089b(g)(1)(C) and discuss such information, as appropriate, with the Mental Health Technical Advisory Group established pursuant to subdivision 9374(e)(2) of this title.~~ [Repealed.]

* * *

Sec. 20. 18 V.S.A. § 9377(g)(1) is amended to read:

(g)(1) Health insurers shall participate in the development of the payment reform strategic plan for the pilot projects and in the implementation of the pilot projects, including providing incentives, fees, or payment methods, as required in this section. This requirement may be enforced by the Department of Financial Regulation to the same extent as the requirement to participate in the Blueprint for Health pursuant to ~~8 V.S.A. § 4088h~~ 8 V.S.A. § 4025.

Sec. 21. 18 V.S.A. § 9381(d) is amended to read:

(d) A decision of the Board's approving, modifying, or disapproving a health insurer's proposed rate pursuant to ~~8 V.S.A. § 4062~~ 8 V.S.A. § 4026 shall be considered a final action of the Board and may be appealed to the Supreme Court pursuant to subsection (b) of this section.

Sec. 22. 18 V.S.A. § 9404(d) is amended to read:

(d) There is hereby created a special fund to be known as the Green Mountain Care Board Regulatory and Administrative Fund pursuant to

32 V.S.A. chapter 7, subchapter 5, for the purpose of providing the financial means for the Green Mountain Care Board to administer its obligations, responsibilities, and duties as required by law, including pursuant to ~~8 V.S.A. § 4062~~ 8 V.S.A. § 4026, chapters 220 and 221 of this title, and 33 V.S.A. chapter 18. All fees, fines, penalties, and similar assessments received by the Board in the administration of its obligations, responsibilities, and duties shall be credited to the Fund. The Fund may also be used by the Department of Health to administer its obligations, responsibilities, and duties as required by chapter 221 of this title.

Sec. 23. 18 V.S.A. § 9414a(a) is amended to read:

(a) As used in this section:

* * *

(5) "Independent external review" means a review of a health care decision by an independent review organization pursuant to ~~8 V.S.A. § 4089f~~ 8 V.S.A. § 4063.

* * *

Sec. 24. 18 V.S.A. § 9462 is amended to read:

§ 9462. QUALITY IMPROVEMENT PROJECTS

~~In addition to reviewing mental health and substance abuse treatment data pursuant to subdivision 9375(b)(12) of this title, the~~ The Green Mountain Care Board shall consider the results of any quality improvement projects not otherwise confidential or privileged undertaken by managed care organizations

for mental health and substance abuse care and treatment pursuant to ~~8 V.S.A. § 4089b(d)(1)(B)(vii) and~~ subsection 9414(i) of this title.

Sec. 25. 18 V.S.A. § 9573(a) is amended to read:

(a) On or before December 31 of each year, the Green Mountain Care Board shall review any all-inclusive population-based payment arrangement between the Department of Vermont Health Access and an accountable care organization for the following calendar year. The Board's review shall include the number of attributed lives, eligibility groups, covered services, elements of the per member, per month payment, and any other nonclaims payments. The Board's review may include deliberative sessions to the same extent permitted for insurance rate review under ~~8 V.S.A. § 4062~~ 8 V.S.A. § 4026.

Sec. 26. 32 V.S.A. § 1407(b) is amended to read:

(b) The State shall bear the costs of forensic medical and psychological examinations administered to victims of crime committed in this State, in instances where that examination is requested by a law enforcement officer or a prosecuting authority of the State or any of its subdivisions and the victim does not have health coverage or the victim's health coverage does not cover the entire cost of the examination. The State shall also bear the costs of sexual assault examinations, as defined in ~~8 V.S.A. § 4089~~ 8 V.S.A. § 4083, administered to victims in cases of alleged sexual assault where the victim obtains such an examination prior to receiving such a request if the victim does not have health coverage or the victim's health coverage does not cover the

entire cost of the examination. If, as a result of a sexual assault examination, the alleged victim has been referred for mental health counseling, the State shall bear any costs of such examination not covered by the victim's health coverage. These costs may be paid from the Victims' Compensation Fund from funds appropriated for that purpose.

Sec. 27. 32 V.S.A. § 10401 is amended to read:

§ 10401. DEFINITIONS

As used in this chapter:

(1) "Health insurance" means any group or individual health care benefit policy, contract, or other health benefit plan offered, issued, renewed, or administered by any health insurer, including any health care benefit plan offered, issued, renewed, or administered by any health insurance company, any nonprofit hospital and medical service corporation, any dental service corporation, or any managed care organization as defined in 18 V.S.A. § 9402. The term includes comprehensive major medical policies, contracts, or plans; short-term, limited-duration health insurance policies and contracts as defined in ~~8 V.S.A. § 4084a~~ 8 V.S.A. § 4053; student health insurance policies; and Medicare ~~supplemental~~ supplement insurance policies, contracts, or plans, but does not include Medicaid or any other State health care assistance program in which claims are financed in whole or in part through a federal program unless authorized by federal law and approved by the General Assembly. The term does not include policies issued for specified disease, accident, injury, hospital

indemnity, long-term care, disability income, or other limited benefit health insurance policies, except that any policy providing coverage for dental services shall be included.

* * *

Sec. 28. 33 V.S.A. § 1813(a)(2) is amended to read:

(2) In its review and approval of premium rates pursuant to ~~8 V.S.A. § 4062~~ 8 V.S.A. § 4026, the Green Mountain Care Board shall ensure that:

* * *

Sec. 29. 33 V.S.A. § 1814 is amended to read:

§ 1814. MAXIMUM OUT-OF-POCKET LIMIT FOR PRESCRIPTION DRUGS IN BRONZE PLANS

(a)(1) Notwithstanding any provision of ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092 to the contrary, the Green Mountain Care Board may approve modifications to the out-of-pocket prescription drug limit established in ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092 for one or more bronze-level plans, as long as the Board finds that the offering of such plans will not adversely impact the plan options available to consumers with high prescription drug needs who benefit from the out-of-pocket prescription drug limit established in ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092.

(2) The Department of Vermont Health Access shall certify at least two standard bronze-level plans that include the out-of-pocket prescription drug limit established in ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092, as long as the plans

comply with federal requirements. Notwithstanding any provision of ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092 to the contrary, the Department may certify one or more bronze-level qualified health benefit plans with modifications to the out-of-pocket prescription drug limit established in ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092.

(b)(1) For each individual enrolled in a bronze-level qualified health benefit plan for the previous two plan years who had out-of-pocket prescription drug expenditures that met the out-of-pocket prescription drug limit established in ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092 for the most recent plan year for which information is available, the health insurer shall, absent an alternative plan selection or plan cancellation by the individual, automatically reenroll the individual in a bronze-level qualified health plan for the forthcoming plan year with an out-of-pocket prescription drug limit at or below the limit established in ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092.

(2) Prior to reenrolling an individual in a plan pursuant to subdivision (1) of this subsection, the health insurer shall notify the individual of the insurer's intent to reenroll the individual automatically in a bronze-level qualified health plan for the forthcoming plan year with an out-of-pocket prescription drug limit at or below the limit established in ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092 unless the individual contacts the insurer to select a different plan and of the availability of bronze-level plans with higher out-of-pocket prescription drug limits. The health insurer shall collaborate with the

Department of Vermont Health Access and the Office of the Health Care Advocate as to the notification's form and content.

Sec. 30. 33 V.S.A. § 4110(a)(6) is amended to read:

(6) ~~For purposes of~~ As used in this section, "dependent coverage" ~~shall have~~ has the same meaning as in ~~8 V.S.A. § 4100b(a)(3)~~ 8 V.S.A. § 4058.

Sec. 31. ADDITIONAL CONFORMING REVISIONS

When preparing the Vermont Statutes Annotated for publication, the Office of Legislative Counsel shall update any additional cross-references to statutes in 8 V.S.A. chapter 107 that use the numbering scheme in effect prior to the effective date of this act to conform to the new numbering scheme enacted by this act.

* * * Interpretation and Rule Alignment * * *

Sec. 32. INTERPRETATION; RULE ALIGNMENT

(a) The purpose of this bill is to update and reorganize the health insurance statutes. It is the intent of the General Assembly that the technical amendments in this act shall not supersede substantive changes contained in other bills enacted by the General Assembly during the current biennium. Where possible, the amendments in this act shall be interpreted to be supplemental to other amendments made to the sections of 8 V.S.A. chapter 107 using the numbering scheme in effect prior to the effective date of this act; to the extent the provisions conflict, the substantive changes in other acts shall take precedence over the technical changes in this act. Statutes added to or

amended in 8 V.S.A. chapter 107 that are enacted during the 2025–2026 biennium using the numbering scheme that existed prior to the effective date of this act shall be codified in the corresponding statutes as renumbered by this act.

(b) Rules adopted and orders, bulletins, forms, and guidance documents issued by the Department of Financial Regulation, the Green Mountain Care Board, and other State agencies that refer to statutes in 8 V.S.A. chapter 107 using the numbering that existed prior to the effective date of this act shall continue to be valid following the effective date of this act until such time as the relevant documents can be amended or updated to align with the renumbering of that chapter by this act.

* * * Effective Date * * *

Sec. 33. EFFECTIVE DATE

This act shall take effect on September 1, 2025.

Date Governor signed bill: May 1, 2025