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H.585

An act relating to health insurance reforms

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

* * * Health Insurer Governance and Executive Compensation * * *

Sec. 1. 8 V.S.A. chapter 123 is amended to read:

CHAPTER 123. NONPROFIT HOSPITAL SERVICE CORPORATIONS

* * *

§ 4512. POWERS

(a) ~~Such~~ A hospital service corporation shall be a nonprofit sharing corporation without capital stock. It shall be maintained and operated solely for the benefit of ~~the~~ its subscribers ~~thereof~~ and shall ensure that benefits and services are balanced with the efficient and economical management of the corporation. A hospital service corporation shall not be authorized to pay money in lieu of hospital service. A person, partnership, association, or corporation shall not contract to furnish hospital service unless authorized ~~to~~ do so pursuant to the provisions of this chapter. Corporations formed under the provisions of this chapter shall have the privileges and be subject to the provisions of Title 11B as well as the applicable provisions of this chapter. In the event of a conflict between the provisions of Title 11B and the provisions of this chapter, the latter shall control.

* * *

1 § 4513. PERMIT TO ENGAGE IN BUSINESS; FOREIGN

2 CORPORATIONS

3 (a) ~~At least three fourths of the board of directors of a corporation~~
4 ~~organized under this chapter shall be composed of subscribers and members of~~
5 ~~the public. The remainder may be providers. The subscriber members of the~~
6 ~~board shall comprise at least a majority of the board. A corporation organized~~
7 ~~under this chapter shall provide for the election of its board of directors at a~~
8 ~~publicly announced meeting. As used in this section, “provider” means any~~
9 ~~person who is a provider of hospital or medical services, or who is an~~
10 ~~employee, director, trustee, or representative of a provider of such services.~~

11 [Repealed.]

12 * * *

13 § 4513a. BOARD OF DIRECTORS

14 (a) Definitions. As used in this section:

15 (1) “Provider” means any person who is a provider of hospital or
16 medical services, or who is an employee, director, trustee, or representative of
17 a provider of such services.

18 (2) “Representative of the public” means any member of the board of
19 directors appointed by the Governor. A representative of the public may be a
20 member of the public, a subscriber, or a provider.

1 (b) Composition. At least three-fourths of the board of directors of a
2 corporation organized under this chapter shall be composed of subscribers and
3 members of the public. The remainder may be providers. The subscriber
4 members of the board shall comprise at least a majority of the board. A
5 corporation organized under this chapter shall provide for the election of its
6 board of directors at a publicly announced meeting.

7 (c) Representatives of the public.

8 (1) Two voting members of the board, but in no event less than one-
9 sixth of the board of directors, shall be representatives of the public appointed
10 by the Governor. Unless otherwise specified in this chapter, a representative
11 of the public shall have the same rights and responsibilities as any other
12 member of the board of directors.

13 (2) The initial term of one representative of the public shall be two years
14 and the initial term of the other representative of the public shall be three years.
15 If there are more than two representatives of the public, their initial terms shall
16 be divided as equally as possible between the two initial term lengths.
17 Thereafter, each representative of the public appointed by the Governor to
18 succeed a representative of the public shall serve a three-year term and shall
19 serve until a successor is appointed.

1 (3) A representative of the public shall be terminated only by the
2 appointing authority, by conclusion of the appointed term, or by voluntary
3 resignation.

4 (4) If a vacancy occurs prior to the conclusion of the three-year term,
5 whether by termination, resignation, or otherwise, the Governor shall appoint a
6 new representative of the public to complete the term.

7 (d) Committees.

8 (1) The board of directors may create one or more committees and may
9 appoint members of the board, including the representatives of the public, to
10 serve on them.

11 (2) The board shall create a compensation committee to review and
12 recommend to the full board for approval all compensation packages offered to
13 the corporation's officers and executives.

14 (A) The compensation committee shall be composed of two or more
15 members, who shall serve at the pleasure of the board of directors.

16 (B) At least two representatives of the public shall be voting
17 members of the compensation committee.

18 (e) Guiding principles for representatives of the public. In discharging the
19 duties of a director, including as a member of a committee, each representative
20 of the public:

1 (1) shall, in determining what the representative of the public reasonably
2 believes to be in the best interests of the hospital service corporation, consider
3 the effects of any action or inaction on:

4 (A) the subscribers of the hospital service corporation;

5 (B) the community and societal considerations of the State of
6 Vermont, including the principles for health care reform expressed in
7 18 V.S.A. § 9371; and

8 (C) the goal that the hospital service corporation's benefits and
9 services should be provided at minimum cost and under efficient and
10 economical management of the corporation;

11 (2) may consider any other relevant factors and the interests of any other
12 group that the representative of the public determines are appropriate to
13 consider; and

14 (3) shall not be required to give priority to the interests of any particular
15 person or group described in subdivision (1) or (2) of this subsection over the
16 interests of any other person or group.

17 (f) No violation of Title 11B. The consideration of interests and factors in
18 the manner described in subsection (e) of this section shall not constitute a
19 violation of Title 11B.

20 (g) Limitations on liability.

1 (2) “Executives” means the president, chief executive officer, chief
2 medical officer, chief administrative officer, chief fiscal officer, vice
3 presidents, and all functionally equivalent roles in a hospital service
4 corporation.

5 (b)(1) On or before July 1, 2026, and prior to approving any changes to the
6 compensation of any executive after that date, each hospital service
7 corporation shall file with the Commissioner of Financial Regulation a
8 statement sworn to by the chair of the corporation’s board of directors and the
9 president of the corporation that includes the following information regarding
10 compensation paid to executives of the corporation:

11 (A) all compensation benchmarks utilized in connection with
12 establishing or awarding compensation for each of the corporation’s
13 executives, including information used by any consultant, vendor, or other
14 third party retained by the corporation;

15 (B) a detailed compensation survey or peer group data used by the
16 corporation or by any consultant, vendor, or other third party retained by the
17 corporation to establish compensation benchmarks or otherwise to establish or
18 award compensation for each of the corporation’s executives; and

19 (C) if any bonus or variable compensation was awarded or paid for
20 the prior fiscal year, the criteria used to evaluate whether that compensation
21 should be paid or awarded and the specific results that supported the payment.

1 Sec. 2. HOSPITAL SERVICE CORPORATIONS; IMPLEMENTATION OF
2 AMENDMENTS TO 8 V.S.A. CHAPTER 123

3 Not later than September 1, 2026, each hospital service corporation
4 operating in this State on July 1, 2026, shall amend its bylaws to comply with
5 the amendments to 8 V.S.A. chapter 123 as set forth in Sec. 1 of this act. The
6 hospital service corporation shall file its amended bylaws with the
7 Commissioner of Financial Regulation for review and approval.

8 * * * Expanding Access to Association Health Plans * * *

9 Sec. 3. 8 V.S.A. § 4041 is amended to read:

10 § 4041. GROUP HEALTH INSURANCE POLICIES; DEFINITIONS

11 (a) As used in this section:

12 (1) “Employees” includes the officers, managers, and employees of the
13 employer; the partners, if the employer is a partnership; the officers, managers,
14 and employees of subsidiary or affiliated corporations of a corporation
15 employer; and the individual proprietors, partners, and employees of
16 individuals and firms, the business of which is controlled by the insured
17 employer through stock ownership, contract, or otherwise.

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

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

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

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

15 (2)(A) Under a policy issued:

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

1 (ii) by a “multiple employer welfare arrangement” that constitutes
2 an “employer,” as those terms are defined in the Employee Retirement Income
3 Security Act of 1974, as amended, and accompanying U.S. Department of
4 Labor regulations and guidance.

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

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

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

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

11 ~~(IV) a constitution and bylaws that provide that:~~

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

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

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

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

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

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

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

9 ~~(cc) common use of office space or equipment used by the~~
10 ~~health insurer to transact insurance. [Repealed.]~~

11 ~~(C) An association's members shall have a shared or common~~
12 ~~purpose that is not primarily a business or customer relationship. [Repealed.]~~

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

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

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

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

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

9 (i) two or more employers;

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

11 or

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

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

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

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

4 Sec. 4. 8 V.S.A. § 4043 is amended to read:

5 § 4043. ASSOCIATION HEALTH PLANS

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

12 ~~(2) No association health plan shall be issued, offered, or renewed in~~
13 ~~this State to any person other than an association that was formed or could~~
14 ~~have been formed under the Employee Retirement Income Security Act of~~
15 ~~1974, 29 U.S.C. § 1001 et seq., and accompanying U.S. Department of Labor~~
16 ~~regulations and guidance, in each case, as in effect as of January 19, 2017 a~~
17 ~~group described in subdivision 4041(b)(2), (3), or (4) of this chapter.~~

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

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

3 (c) ~~The~~ Notwithstanding any statute or rule to the contrary, the provisions
4 of ~~section~~ sections 3661 and 4042 of this title shall apply to fully insured
5 association health plans.

6 Sec. 5. ASSOCIATION HEALTH PLANS; FEDERAL LANDSCAPE;
7 MARKET IMPACTS; RATE REVIEW; REPORT

8 On or before January 15, 2027, the Department of Financial Regulation
9 shall report to the House Committee on Health Care and the Senate
10 Committees on Health and Welfare and on Finance the following information
11 related to expanding access to association health plans beginning on January 1,
12 2028, as permitted by 8 V.S.A. §§ 4041 and 4043, as amended by Secs. 3 and
13 4 of this act:

14 (1) the status of federal law regarding association health plans, including
15 the extent to which federal law would allow for the expanded access to
16 association health plans in Vermont beginning on January 1, 2028;

17 (2) an analysis of the projected impacts on Vermont's health insurance
18 markets of expanding access to association health plans beginning on January
19 1, 2028, including the likely effects on enrollment in and premiums for
20 qualified health benefit plans in the individual and small group markets, using
21 scenarios that show potential impacts over consecutive years if various

1 percentages of healthier lives were to leave the individual and the small group
2 markets to enroll in association health plans; and

3 (3) in consultation with the Green Mountain Care Board, the potential
4 impact of expanding access to association health plans beginning on January 1,
5 2028, on the Green Mountain Care Board’s health insurance rate review
6 responsibilities pursuant to 8 V.S.A. § 4026.

7 * * * Defining “High-Dollar Claims” for Claims Edit Purposes * * *

8 Sec. 6. 18 V.S.A. § 9418a is amended to read:

9 § 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE

10 TO CODING RULES

11 * * *

12 (e)(1) Except as otherwise provided in subdivision (2) of this subsection,
13 no health plan, contracting entity, covered entity, or payer shall subject any
14 health care provider to prepayment coding validation edit review. As used in
15 this subsection, “prepayment coding validation edit review” means any action
16 by the health plan, contracting entity, covered entity, or payer, or by a
17 contractor, assignee, agent, or other entity acting on its behalf, requiring a
18 health care provider to provide medical record documentation in conjunction
19 with or after submission of a claim for payment for health care services
20 delivered, but before the claim has been adjudicated.

1 Sec. 8. SITE-NEUTRAL REIMBURSEMENT FOR PHYSICAL
2 THERAPY, OCCUPATIONAL THERAPY, AND ATHLETIC
3 TRAINING; IMPLEMENTATION REPORT

4 On or before March 1, 2027, each health insurer that is required to make
5 site-neutral reimbursements for physical therapy, occupational therapy, and
6 athletic training items and services pursuant to 18 V.S.A. § 9423, as added by
7 Sec. 7 of this act, shall provide an update to the House Committee on Health
8 Care and the Senate Committees on Health and Welfare and on Finance
9 regarding its implementation of the site-neutral reimbursements, any trends or
10 other financial impacts it has identified so far as a result of implementation,
11 and any recommendations regarding the enactment of additional site-neutral
12 reimbursement requirements.

13 * * * Increasing Flexibility in Health Insurance Plan Design * * *

14 Sec. 9. INCREASING FLEXIBILITY IN HEALTH INSURANCE PLAN
15 DESIGN; REPORT

16 The Department of Vermont Health Access, in consultation with the
17 Department of Financial Regulation, shall consider the feasibility and potential
18 impacts on premiums and on plan design of allowing health insurers to offer
19 health insurance plans in the large group market and at each metal level in the
20 individual and small group markets that do not include the out-of-pocket limits
21 for prescription drugs established in 8 V.S.A. § 4092, provided the health

1 insurers also offer plans in the same markets that do include the out-of-pocket
2 limits for prescription drugs established in 8 V.S.A. § 4092. On or before
3 January 15, 2027, the Department of Vermont Health Access shall provide its
4 findings and recommendations for increasing flexibility in health insurance
5 plans' out-of-pocket prescription drug limits to the House Committee on
6 Health Care and the Senate Committees on Health and Welfare and on
7 Finance.

8 * * * Annual Reporting on Health Care Sharing Plans and Arrangements * * *

9 Sec. 10. 8 V.S.A. chapter 115 is added to read:

10 CHAPTER 115. HEALTH CARE SHARING PLANS

11 § 4271. HEALTH CARE SHARING PLAN OR ARRANGEMENT;

12 REPORTING AND CERTIFICATION

13 (a) A person that is not authorized by the Commissioner under chapter 101,
14 123, 125, or 139 of this title to offer insurance in this State and that offers or
15 intends to offer a plan or arrangement to facilitate payment or reimbursement
16 of health care costs or services for residents of this State, regardless of whether
17 the person is domiciled in this State or another state, shall submit to the
18 Commissioner on or after October 1, 2026, and on or after March 1 each year
19 thereafter:

1 (1) the following information:

2 (A) the total number of individuals and households that participated
3 in the plan or arrangement in this State in the immediately preceding calendar
4 year;

5 (B) the total number of employer groups that participated in the plan
6 or arrangement in this State in the immediately preceding calendar year,
7 specifying the total number of participating individuals in each participating
8 employer group;

9 (C) if the person offers a plan or arrangement in other states, the total
10 number of participants in the plan or arrangement nationally;

11 (D) any contracts the person has entered into with providers in this
12 State who provide health care services to plan or arrangement participants;

13 (E) the total amount of fees, dues, or other payments collected by the
14 person in the immediately preceding calendar year from individuals, employer
15 groups, or others that participated in the plan or arrangement, specifying the
16 percentage of fees, dues, or other payments retained by the person for
17 administrative expenses;

18 (F) the total dollar amount of requests for reimbursement of health
19 care costs or services that were submitted in this State in the immediately
20 preceding calendar year by plan or arrangement participants or providers who
21 provided health care services to plan or arrangement participants;

1 (G) the total dollar amount of requests for reimbursement of health
2 care costs or services that were submitted in this State and were determined to
3 qualify for reimbursement under the plan or arrangement in the immediately
4 preceding calendar year;

5 (H) the total dollar amount of payments made to providers in this
6 State in the immediately preceding calendar year for health care services that
7 were provided to or received by plan or arrangement participants;

8 (I) the total dollar amount of reimbursements made to plan or
9 arrangement participants in this State in the immediately preceding calendar
10 year for health care services provided to or received by a plan or arrangement
11 participant;

12 (J) the total number of requests for reimbursement of health care
13 costs or services submitted in this State in the immediately preceding calendar
14 year that were denied, expressed as a percentage of total reimbursement
15 requests submitted in that calendar year, and the total number of
16 reimbursement request denials that were appealed;

17 (K) the total dollar amount of health care expenses submitted in this
18 State by plan or arrangement participants or providers in the immediately
19 preceding calendar year that qualify for reimbursement pursuant to the plan or
20 arrangement criteria but that, as of the end of that calendar year, have not been
21 reimbursed, excluding any amounts that the plan or arrangement participants

1 incurring the health care costs must pay before receiving reimbursement under
2 the plan or arrangement;

3 (L) the estimated number of plan or arrangement participants the
4 person anticipates in this State in the next calendar year, specifying the number
5 of individuals, households, employer groups, and employees;

6 (M) a list of other states in which the person offers a plan or
7 arrangement;

8 (N) a list of any third parties, other than a licensed insurance
9 producer, that are associated with or assist the person in offering or enrolling
10 participants in this State in the plan or arrangement, copies of any training
11 materials provided to a third party, and a detailed accounting of any
12 commissions or other fees or remuneration paid to a third party in the
13 immediately preceding calendar year for:

14 (i) marketing, promoting, or enrolling participants in a plan or
15 arrangement offered by the person in this State; or

16 (ii) operating, managing, or administering a plan or arrangement
17 offered by the person in this State;

18 (O) the total number of licensed insurance producers that are
19 associated with or assist the person in offering or enrolling participants in this
20 State in the plan or arrangement, the total number of participants enrolled in
21 the plan or arrangement through a licensed insurance producer, copies of any

1 training materials provided to a producer, and a detailed accounting of any
2 commissions or other fees or remuneration paid to a producer in the
3 immediately preceding calendar year for marketing, promoting, or enrolling
4 participants in a plan or arrangement offered by the person in this State;

5 (P) copies of any consumer-facing and marketing materials used in
6 this State in promoting the person's plan or arrangement, including plan or
7 arrangement descriptions, benefit descriptions, and other materials that explain
8 the plan or arrangement;

9 (Q) the name, mailing address, email address, and telephone number
10 of an individual serving as a contact for the person in this State;

11 (R) a list of any parent companies, subsidiaries, and other names that
12 the person has operated under at any time within the immediately preceding
13 five calendar years; and

14 (S) an organizational chart of the person and a list of the officers and
15 directors of the person; and

16 (2) a certification by an officer of the person that, to the best of the
17 person's good-faith knowledge and belief, the information submitted is
18 accurate and satisfies the requirements of this subsection.

19 (b)(1) If a person subject to the requirements of subsection (a) of this
20 section fails to submit the information required by that subsection, the
21 submission is incomplete. The Commissioner shall make a determination of

1 completeness not later than 45 days after the submission is received. If the
2 Commissioner has not informed the person of any deficiencies in the
3 submission within 45 days after receiving the submission, the submission is
4 considered complete.

5 (2)(A) If the Commissioner determines that a person has failed to
6 comply with the requirements of subsection (a) of this section, the
7 Commissioner shall:

8 (i) notify the person that the submission is incomplete and
9 enumerate in the notification each deficiency found in the person's submission;
10 and

11 (ii) allow the person 30 days after notice of the incomplete
12 submission to remedy the deficiency found in the submission.

13 (B) If the person does not remedy the deficiency within the 30-day
14 period, the Commissioner may impose an administrative penalty not to exceed
15 \$5,000.00 per day.

16 (C) If the person does not remedy the deficiency or deficiencies
17 within 30 days after the initial administrative penalty is imposed, the
18 Commissioner may issue a cease and desist order pursuant to section 2110 of
19 this title.

20 (c) On or before April 1, 2027, and on or before each October 1 thereafter,
21 the Commissioner shall:

