TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred House Bill No. 585 entitled "An act relating to health insurance reforms" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * 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 ~~so~~ 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.

* * *

§ 4513. PERMIT TO ENGAGE IN BUSINESS; FOREIGN CORPORATIONS

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or medical services, or who is an employee, director, trustee, or representative of a provider of such services.~~ [Repealed.]

* * *

§ 4513a. BOARD OF DIRECTORS

(a) Definitions. As used in this section:

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

(2) "Representative of the public" means any member of the board of directors appointed by the Governor [Legislature/process?]. A representative of the public may be a member of the public, a subscriber, or a provider.

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

(c) Representatives of the public.

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

(2) The initial term of one representative of the public shall be two years and the initial term of the other representative of the public shall be three years. If there are more than two representatives of the public, their initial terms shall be divided as equally as possible between the two initial term lengths. Thereafter, each representative of the public appointed by the Governor

[Legislature/process?] to succeed a representative of the public shall serve a three-year term and shall serve until a successor is appointed.

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

(4) If a vacancy occurs prior to the conclusion of the three-year term, whether by termination, resignation, or otherwise, the Governor [Legislature/process?] shall appoint a new representative of the public to complete the term.

(d) Committees.

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

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

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

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

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

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

(A) the subscribers of the hospital service corporation;

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

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

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

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

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

(g) Limitations on liability.

(1) A representative of the public is not liable for the failure of the hospital service corporation to create general or specific impacts on the community or the health care system.

(2) A representative of the public is not liable to the hospital service corporation for any action or failure to take action in the representative's official capacity if the representative of the public performed the duties of the office in compliance with Title 11B and this section. In the event of a conflict between Title 11B and this chapter, this chapter shall control.

(3) A representative of the public shall have no duty to any person who is a beneficiary of the general or specific public benefit purposes of a hospital service corporation arising solely from the person's status as a beneficiary of the general or specific public benefit.

(h) Bylaws. Any new hospital benefit corporation shall adopt bylaws in accordance with the requirements of this chapter and Title 11B. All bylaws shall be filed with the Commissioner of Financial Regulation for review and approval.

* * *

§ 4516a. EXECUTIVE COMPENSATION

(a) As used in this section:

(1) "Compensation" means total cash compensation, including base salary and annual incentive compensation.

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

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

~~(1)~~**(A)** all compensation benchmarks utilized in connection with establishing or awarding compensation for each of the corporation's executives, including information used by any consultant, vendor, or other third party retained by the corporation;

~~(2)~~**(B)** a detailed compensation survey or peer group data used by the corporation or by any consultant, vendor, or other third party retained by the

corporation to establish compensation benchmarks or otherwise to establish or award compensation for each of the corporation's executives; and

~~(3)~~**(C)** if any bonus or variable compensation was awarded or paid for the prior fiscal year, the criteria used to evaluate whether that compensation should be paid or awarded and the specific results that supported the payment.

(2) All information provided pursuant to this subsection shall be sufficiently detailed to allow for a comprehensive examination of the benchmarks and to enable the Commissioner or designee to perform independent computations to evaluate the benchmarks provided.

(c) The Commissioner may require the corporation to modify a group described in subdivision (b)(2) of this section if, in the Commissioner's discretion, the group contains entities that are not sufficiently similar to the corporation in terms of size, business, operations, nonprofit status, or other factors.

(d) The Commissioner may retain at the corporation's expense such outside consultants and other experts as are reasonably necessary to assist the Commissioner in evaluating the materials provided pursuant to this section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(e) Nothing in this section shall be construed to preclude a corporation from segregating and designating any materials provided to the Commissioner

under this section as confidential due to content that is proprietary, privileged, or otherwise confidential under Vermont law, and the Commissioner shall maintain the confidentiality of the information as appropriate under the Public Records Act.

* * *

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

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

~~* * * Limited Age Rating * * *~~

~~Sec. 3. 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 33 V.S.A. § 1811(f)(2)(B).~~

~~Sec. 4. 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 33 V.S.A. § 1811(f)(2)(B).~~

~~Sec. 5. 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 33 V.S.A. § 1811(f)(2)(B).~~

~~Sec. 6. DEPARTMENT OF FINANCIAL REGULATION; HEALTH INSURANCE PLANS; LIMITED AGE RATING~~

~~The Department of Financial Regulation shall review and amend its rules and guidance as needed to allow health insurers to use age classifications in the premiums charged for their individual and small group plans starting in the 2028 plan year, provided that the premium charged to any cohort shall not deviate by more than five percent above or below the community rate filed by the health insurer pursuant to 8 V.S.A. § 4026.~~

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

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

§ 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" that constitutes an "employer," as those terms are defined in the Employee Retirement Income Security Act of 1974, as amended, and accompanying U.S. Department of Labor regulations and guidance.

(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.~~ [Repealed.]

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

(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.

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

§ 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~~ a group described in subdivision 4041(b)(2), (3), or (4) of this chapter.

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

* * * Expanding Access to Short-Term, Limited-Duration Plans * * *

Sec. 5. 8 V.S.A. § 4053 is amended to read:

§ 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~~ has the same meaning as "short-term, limited-duration insurance" in 45 C.F.R. § 144.103.

(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~~ not have a duration of longer than 12 months in total, taking into account any renewals or extensions.

(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.

* * * Defining "High-Dollar Claims" for Claims Edit Purposes * * *

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

§ 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES

* * *

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

(2) Nothing in this subsection shall be construed to prohibit targeted prepayment coding validation edit review of a specific provider, provider group, or facility under certain circumstances, including evaluating ~~high-dollar~~ claims exceeding $25,000.00 per episode of care; verifying complex financial arrangements; investigating member questions; conducting post-audit monitoring; addressing a reasonable belief of fraud, waste, or abuse; or other circumstances determined by the Commissioner through a bulletin or guidance.

* * *

~~* * * Limiting Prior Authorization Exemptions for Primary Care * * *~~

~~Sec. 11. 18 V.S.A. § 9418b is amended to read:~~

~~§ 9418b. PRIOR AUTHORIZATION~~

~~* * *~~

~~(c)(1)(A) Except as provided in subdivision (B) of this subdivision (1), a health plan shall not impose any prior authorization requirement for any admission, item, service, treatment, or procedure ordered by a primary care provider who practices at an independent physician practice that is not owned or affiliated with a hospital or hospital network and who is not employed by or otherwise under the control of a hospital or hospital network.~~

~~(B) The prohibition set forth in subdivision (A) of this subdivision (1) shall not be construed to prohibit prior authorization requirements for prescription drugs or for an admission, item, service, treatment, or procedure that is provided out-of-network.~~

~~(2) As used in this subsection, "primary care provider" means a health care provider who is contracted and enrolled with the health plan as a primary care provider.~~

~~* * *~~

* * * Site-Neutral Billing **for Physical Therapy Services** * * *

~~Sec. 12. 18 V.S.A. § 9376 is amended to read:~~

~~§ 9376. PAYMENT AMOUNTS; METHODS~~

~~(a) Intent. It is the intent of the General Assembly:~~

~~(1) to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide,~~

~~on a solvent basis, effective and efficient health care services that are in the public interest. It is also the intent of the General Assembly;~~

~~(2) to eliminate the shift of costs between the payers of health care services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health care services are available to all Vermonters and are distributed equitably; and~~

~~(3) that payments for health care services that can be delivered safely and affordably outside a hospital setting should be standardized regardless of the health care setting in which they are delivered.~~

~~* * *~~

~~(f) Site-neutral billing.~~

~~(1) The Board, in coordination with the Department of Financial Regulation, shall identify outpatient or ambulatory items and services that are safe and appropriate to be delivered in lower-cost, nonhospital settings. For each of these items and services, the Board shall establish a single reference-based price that shall be applied in all hospital and nonhospital service locations across Vermont, based on a percentage of the Medicare reimbursement rate for the same or a similar item or service or on another benchmark, as appropriate, using the same parameters as set forth in subdivision (e)(2)(A) of this section.~~

~~(2)(A) In developing site-neutral, reference-based prices for site-neutral billing pursuant to this subsection (f), the Board and the Department shall consult with health insurers, hospitals, other health care professionals as applicable; the Office of the Health Care Advocate; and the Agency of Human Services.~~

~~(B) The Board shall implement site-neutral billing in a manner that does not allow health care professionals to charge or collect from patients or health insurers, and does not allow health insurers to pay, any amount for the outpatient or ambulatory item or service in excess of the site-neutral, reference-based amount established by the Board.~~

~~(3) The Board shall identify factors that would necessitate terminating or modifying the use of site-neutral billing, such as a measurable reduction in access to or quality of care.~~

~~(4) The Board's authority to implement site-neutral billing pursuant to this subsection shall not include the authority to set amounts applicable to outpatient or ambulatory items provided or services delivered to patients who are enrolled in Medicare or Medicaid.~~

Sec. 7. 18 V.S.A. § 9423 is added to read: **(NEW)**

§ 9423. SITE-NEUTRAL REIMBURSEMENT FOR PHYSICAL THERAPY ~~SERVICES~~

Each health plan shall establish and pay reimbursement amounts for all physical therapy items and services provided to its insureds that are **uniform and** consistent across all of the health plan's contracts and fee schedules, except that a plan may reimburse different amounts for physical therapy **items and services** delivered in an inpatient setting. Health plans shall express each reimbursement amount as a percentage of the Medicare rate for the same item or service.

Sec. 8. SITE-NEUTRAL REIMBURSEMENT FOR PHYSICAL THERAPY; IMPLEMENTATION REPORT **(NEW)**

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

~~* * * Section 1332 Reinsurance Waiver * * *~~

~~Sec. 13. REINSURANCE; AUTHORIZATION TO PURSUE SECTION 1332 WAIVER~~

~~The Department of Vermont Health Access, in consultation with the Department of Financial Regulation, is authorized to submit a State Innovation Waiver pursuant to Section 1332 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, to establish a program for reinsurance and seek federal pass-through funding of amounts attributable to premium tax credits under 26 U.S.C. § 36B and cost-sharing reductions under 42 U.S.C. § 18071.~~

* * * Eliminating Prescription Drug-Specific Out-of-Pocket Maximums * * *

Sec. 9. 8 V.S.A. § 4092 is amended to read: **(NEW)**

§ 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.~~ [Repealed.]

(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.~~ [Repealed.]

* * *

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

Sec. 10. 8 V.S.A. chapter 115 is added to read: **(NEW; from H.102)**

CHAPTER 115. HEALTH CARE SHARING PLANS

§ 4271. HEALTH CARE SHARING PLAN OR ARRANGEMENT; REPORTING AND CERTIFICATION

(a) A person that is not authorized by the Commissioner under chapter 101, 123, 125, or 139 of this title to offer insurance in this State and that offers or intends to offer a plan or arrangement to facilitate payment or reimbursement of health care costs or services for residents of this State, regardless of whether the person is domiciled in this State or another state, shall submit to the

Commissioner on or after October 1, 2026, and on or after March 1 each year thereafter:

(1) the following information:

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

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

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

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

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

(F) the total dollar amount of requests for reimbursement of health care costs or services that were submitted in this State in the immediately

preceding calendar year by plan or arrangement participants or providers who provided health care services to plan or arrangement participants;

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

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

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

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

(K) the total dollar amount of health care expenses submitted in this State by plan or arrangement participants or providers in the immediately preceding calendar year that qualify for reimbursement pursuant to the plan or

arrangement criteria but that, as of the end of that calendar year, have not been reimbursed, excluding any amounts that the plan or arrangement participants incurring the health care costs must pay before receiving reimbursement under the plan or arrangement;

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

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

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

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

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

(O) the total number of licensed insurance producers that are associated with or assist the person in offering or enrolling participants in this

State in the plan or arrangement, the total number of participants enrolled in the plan or arrangement through a licensed insurance producer, copies of any training materials provided to a producer, and a detailed accounting of any commissions or other fees or remuneration paid to a producer in the immediately preceding calendar year for marketing, promoting, or enrolling participants in a plan or arrangement offered by the person in this State;

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

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

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

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

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

(b)(1) If a person subject to the requirements of subsection (a) of this section fails to submit the information required by that subsection, the submission is incomplete. The Commissioner shall make a determination of completeness not later than 45 days after the submission is received. If the Commissioner has not informed the person of any deficiencies in the submission within 45 days after receiving the submission, the submission is considered complete.

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

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

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

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

(C) If the person does not remedy the deficiency or deficiencies within 30 days after the initial administrative penalty is imposed, the

Commissioner may issue a cease and desist order pursuant to section 2110 of this title.

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

(1) prepare a written report summarizing the information submitted by persons pursuant to subsection (a) of this section; and

(2) post the report on the Department's website, along with accurate and evidence-based information about the persons that submitted information pursuant to subsection (a) of this section, including how consumers may file complaints.

(d) The Commissioner may adopt rules as necessary to implement this section.

* * * Effective Date * * *

Sec. 11. EFFECTIVE DATES

This act shall take effect on July 1, 2026**, except that Sec. 7 (18 V.S.A. § 9423; site-neutral reimbursements for physical therapy) shall take effect on October 1, 2026 and shall apply to physical therapy items provided and services delivered on and after that date**.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE