

1 Introduced by
2 Referred to Committee on
3 Date:
4 Subject: Health; health insurance; Vermont Statutes Annotated
5 Statement of purpose of bill as introduced: This bill proposes to update and
6 reorganize the health insurance chapter, 8 V.S.A. chapter 107, including using
7 consistent language and terminology throughout the chapter. The bill would
8 also update cross-references in other statutes as needed.

9 An act relating to updating and reorganizing the health insurance statutes in
10 8 V.S.A. chapter 107

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

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

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

14 8 V.S.A. chapter 107 (health insurance) is repealed.

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

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

17 CHAPTER 107. HEALTH INSURANCE

18 Subchapter 1. General Provisions

19 § 4011. DEFINITIONS (formerly § 4061; mostly new/moved from in chapter)

20 As used in this chapter:

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

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

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

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

17 (5) “Major medical insurance” means a comprehensive health insurance
18 plan that is not specific disease, accident, hospital indemnity, dental care,
19 vision care, disability income, long-term care, Medicare supplement insurance,
20 or other limited-benefit coverage. The term does not include short-term,
21 limited-duration health insurance coverage or a plan under which benefits are

1 paid directly to a covered individual or the individual's assigns and for which
2 the amount of the benefit is not based on potential medical costs or on actual
3 costs incurred.

4 § 4012. COMPLIANCE WITH FEDERAL LAW (formerly § 4062c)

5 (a) Except as otherwise provided in this title, health insurers, hospital and
6 medical service corporations, and health maintenance organizations that issue,
7 sell, renew, or offer health insurance ~~coverage~~ plans in Vermont shall comply
8 with the requirements of the Health Insurance Portability and Accountability
9 Act of 1996, as amended from time to time (42 U.S.C. Chapter 6A, Subchapter
10 XXV), and the Patient Protection and Affordable Care Act of 2010, Pub. L.
11 No. 111-148, as amended by the Health Care and Education Reconciliation Act
12 of 2010, Pub. L. No. 111-152. The Commissioner shall enforce such
13 requirements pursuant to the Commissioner's authority under this title.

14 (b)(1) Health insurers, hospital and medical service corporations, health
15 maintenance organizations, and health care providers, as that term is defined in
16 18 V.S.A. § 9432, shall comply with the requirements of the No Surprises Act,
17 Pub. L. No. 116-260, Division BB, Title I, as amended from time to time.

18 (2) The Commissioner shall enforce the requirements of the No
19 Surprises Act as they apply to health insurers, hospital and medical service
20 corporations, health maintenance organizations, and health care providers, to
21 the extent permitted under federal law, pursuant to the Commissioner's

1 authority under this title. The Commissioner may also refer cases of
2 noncompliance to the U.S. Department of Health and Human Services under
3 the terms of a collaborative enforcement agreement, or to the Office of the
4 Vermont Attorney General.

5 § 4013. DISCRIMINATION PROHIBITED (formerly § 4083)

6 ~~No insurer doing in this State the business specified in subdivision~~
7 ~~3301(a)(2) of this title~~ No health insurer shall make or permit any unfair
8 discrimination between individuals of substantially the same hazard in the
9 amount of premium rates charged for any ~~policy or contract of such insurance~~
10 health insurance plan or in the benefits payable ~~thereunder~~. ~~This section~~ under
11 the plan; provided, however, that this section shall not be construed to prohibit
12 different premium rates, different benefits, or different underwriting procedure
13 for individuals insured under group, family expense, franchise, or blanket plans
14 of insurance.

15 § 4014. ADVERTISING PRACTICES (formerly § 4084; no changes)

16 (a) No company doing business in this State, and no insurance agent or
17 broker, shall use in connection with the solicitation of health insurance or
18 pharmacy benefit management any advertising copy or advertising practice or
19 any plan of solicitation that is materially misleading or deceptive. An
20 advertising copy or advertising practice or plan of solicitation shall be
21 considered to be materially misleading or deceptive if by implication or

1 otherwise it transmits information in such manner or of such substance that a
2 prospective applicant for health insurance may be misled by it to the
3 applicant's material damage.

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

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

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

16 § 4015. PENALTIES FOR VIOLATIONS (formerly § 4087)

17 ~~Any person, partnership, or corporation wilfully violating The~~
18 Commissioner may impose an administrative penalty of up to \$750.00 on any
19 person who intentionally violates any provision of this chapter or any order of
20 the Commissioner made in accordance with this chapter shall pay an
21 ~~administrative penalty to the people of the State a sum not to exceed \$750.00~~

1 ~~for each such violation.~~ The Commissioner may also suspend or revoke the
2 license of ~~an~~ a health insurer or agent for any such ~~willful~~ intentional violation.

3 § 4016. APPEAL (formerly § 4088)

4 (a) Any person, ~~partnership, or corporation~~ aggrieved by any action of the
5 Commissioner may obtain a review by appeal to the Superior Court ~~within and~~
6 ~~for the County~~ of Washington County. ~~Such~~ The appeal shall be based on the
7 ~~basis of the~~ record of the proceedings before the Commissioner and shall not
8 be limited to questions of law. If the appeal is from an order of the
9 Commissioner, ~~such~~ the order shall not take effect during the pendency of the
10 appeal unless the court ~~shall determine~~ determines otherwise.

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

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

16 § 4017. EXEMPTION FROM ATTACHMENT AND TRUSTEE PROCESS
17 (formerly § 4086)

18 So much of any benefits under all policies of health insurance as does not
19 exceed \$200.00 for each month during any period of disability covered ~~thereby~~
20 by the policy shall not be liable to attachment, trustee process, or other process,
21 or to be seized, taken, appropriated, or applied by any legal or equitable

1 process or by operation of law, either before or after payment of such benefits,
2 to pay any debt or liabilities of the person insured under ~~such~~ the policy.
3 However, this exemption shall not apply where an action is brought to recover
4 for necessities contracted for during ~~such~~ the period of disability and the writ
5 or bill of complaint contains a statement to that effect. When a policy provides
6 for a lump sum payment because of a dismemberment or other loss insured,
7 ~~such~~ the payment shall be exempt from execution of the ~~insured's~~ covered
8 individual's creditors.

9 § 4018. THIRD-PARTY OWNERSHIP (formerly § 4069)

10 ~~The word “insured,” as used in~~ Nothing in this chapter, shall ~~not~~ be
11 construed as preventing a person other than the ~~insured~~ covered individual with
12 proper insurable interest from making application for and owning a policy
13 covering the ~~insured~~ covered individual or from being entitled under such a
14 policy to any indemnities, benefits, and rights provided ~~therein~~ in the policy.

15 § 4019. NOTICE AS WAIVER (formerly § 4074)

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

1 ~~The acknowledgment by any insurer of the receipt of notice given under~~
2 ~~any such policy, or the furnishing of forms for filing proofs of loss, or the~~
3 ~~acceptance of such proofs, or the investigation of any claim thereunder shall~~
4 ~~not operate as a waiver of any of the rights of the insurer in defense of any~~
5 ~~claim arising under such policy.~~

6 § 4020. AGE LIMITS (formerly § 4075)

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

15 (b) ~~In the event~~ Notwithstanding any provision of subsection (a) of this
16 section to the contrary, if the age of the ~~insured~~ covered individual has been
17 misstated and if, according to the correct age of the ~~insured~~ covered individual,
18 the coverage provided by the policy would not have become effective, or
19 would have ceased prior to the health insurer's acceptance of ~~such~~ the
20 premium or premiums, then the health insurer's liability ~~of the insurer~~ shall be

1 limited to the refund, upon request, of all premiums paid for the period not
2 covered by the ~~policy plan~~.

3 § 4021. TERMINATION OF COVERAGE (formerly § 4077 and § 4089h)

4 (a)(1) A ~~comprehensive~~ major medical insurance policy issued by a health
5 ~~insurance company, nonprofit hospital or medical service corporation, or~~
6 ~~health maintenance organization~~ insurer that insures employees, members, or
7 subscribers for hospital and medical insurance on an expense-incurred, service,
8 or prepaid basis shall:

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

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

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

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

5 ~~(a)(b)~~ Except as otherwise provided for comprehensive major medical
6 ~~insurance coverage in section 4077 of this chapter,~~ For all health insurance
7 policies other than major medical insurance policies, a health insurer shall
8 notify a policyholder of any premium payment due on a policy at least 21 days
9 before the due date. If ~~an~~ a health insurer does not receive payment by the due
10 date, ~~an~~ the health insurer shall send a termination notice to the policyholder
11 notifying the policyholder that the health insurer will terminate the policy
12 effective on the due date if payment is not received within 14 days from the
13 date of mailing of the termination notice. If ~~an~~ a health insurer does not
14 receive payment within 14 days from the date of mailing of the termination
15 notice, ~~an~~ the health insurer may cancel coverage effective on the due date.

16 ~~(b) As used in this section, “health insurer” means a health insurance~~
17 ~~company, a hospital or medical service corporation, or a health maintenance~~
18 ~~organization that issues or renews any individual policy, service contract, or~~
19 ~~benefit plan in this State.~~

20 § 4022. REBATES AND COMMISSIONS PROHIBITED FOR NONGROUP
21 AND SMALL GROUP POLICIES AND PLANS OFFERED

1 THROUGH THE VERMONT HEALTH BENEFIT EXCHANGE

2 (formerly § 4085)

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

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

6 (A) any rebate of or part of the premium payable on a health
7 insurance plan issued pursuant to ~~section 4080g of this title or~~ 33 V.S.A.
8 § 1811 or earnings, profits, dividends, or other benefits founded, arising,
9 accruing or to accrue ~~thereon or therefrom, or~~ on or from the premium;

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

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

12 (D) any other valuable consideration or inducement to or for
13 insurance on any risk in this State, ~~now or hereafter to be written,~~ or for or
14 upon any renewal of any such insurance, ~~which that~~ is not specified in the
15 ~~policy contract of insurance,~~ health insurance plan; or

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

1 (b) No person insured under a health insurance plan issued pursuant to
2 ~~section 4080g of this title or~~ 33 V.S.A. § 1811 or party or applicant for such
3 plan shall directly or indirectly receive or accept or agree to receive or accept
4 any rebate of premium or of any part ~~thereof~~ of the premium, or any favor or
5 advantage, or share in any benefit to accrue under any health insurance plan
6 issued pursuant to ~~section 4080g of this title or~~ 33 V.S.A. § 1811, or any
7 valuable consideration or inducement, ~~other than such as is~~ that is not specified
8 in the health insurance plan.

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

11 (1) allowing or returning to its participating policyholders dividends,
12 savings, or unused premium deposits; ~~or as prohibiting any insurer from~~

13 (2) returning or otherwise abating, in full or in part, the premiums of its
14 policyholders out of surplus accumulated from nonparticipating insurance, ~~or~~
15 ~~as prohibiting the~~

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

18 (d)(1) No insurer shall pay any commission, fee, or other compensation,
19 directly or indirectly, to a licensed or unlicensed agent, broker, or other
20 individual in connection with the sale of a health insurance plan issued
21 pursuant to ~~section 4080g of this title or~~ 33 V.S.A. § 1811, nor shall ~~an~~ a health

1 insurer include in an insurance rate for a health insurance plan issued pursuant
2 to ~~section 4080g of this title or~~ 33 V.S.A. § 1811 any sums related to services
3 provided by an agent, broker, or other individual. A health insurer may
4 provide to its ~~employees'~~ employees wages, salary, and other employment-
5 related compensation in connection with the sale of health insurance plans, but
6 ~~may~~ shall not structure any such compensation in a manner that promotes the
7 sale of particular health insurance plans over other plans offered by that
8 insurer.

9 (2) Nothing in this subsection shall be construed to prohibit the Vermont
10 Health Benefit Exchange established in 33 V.S.A. chapter 18, subchapter 1
11 from structuring compensation for agents or brokers in the form of an
12 additional commission, fee, or other compensation outside insurance rates or
13 from compensating agents, brokers, or other individuals through the
14 procedures and payment mechanisms established pursuant to 33 V.S.A.
15 § 1805(17).

16 § 4022a. REBATES PROHIBITED FOR GROUP INSURANCE POLICIES
17 (formerly § 4085a)

18 (a) As used in this section, “group insurance” means any policy described
19 in section ~~4079~~ 4041 of this title, except that it shall not include any small
20 group policy issued pursuant to ~~section 4080a or 4080g of this title or to~~ 33
21 V.S.A. § 1811.

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

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

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

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

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

11 (D) any other valuable consideration or inducement to or for
12 insurance on any risk in this State, ~~now or hereafter to be written~~, or for or
13 upon any renewal of any such insurance, ~~which that~~ that is not specified in the
14 ~~policy contract of insurance~~, health insurance plan; or

15 (2) offer, promise, give, option, sell, or purchase any stocks, bonds,
16 securities, or property, or any dividends or profits accruing or to accrue ~~thereon~~
17 on them, or other thing of value ~~whatsoever~~ as inducement to insurance or in
18 connection ~~therewith~~ with insurance, or any renewal thereof, ~~which that~~ that is not
19 specified in the ~~policy~~ health insurance plan.

20 (c) No ~~insured~~ person insured under a group insurance policy or party
21 or applicant for group insurance shall directly or indirectly receive or accept or

1 agree to receive or accept any rebate of premium or of any part ~~thereof~~ of the
2 premium, or all or any part of any agent's or broker's commission ~~thereon~~ on
3 the premium, or any favor or advantage, or share in any benefit to accrue under
4 any ~~policy of insurance~~ health insurance plan, or any valuable consideration or
5 inducement, ~~other than such as is specified in the policy~~ that is not specified in
6 the health insurance plan.

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

8 (1) the payment of commission or other compensation to any duly
9 licensed agent or broker; ~~or as prohibiting~~

10 (2) any health insurer from allowing or returning to its participating
11 policyholders dividends, savings, or unused premium deposits; ~~or as~~
12 ~~prohibiting~~

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

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

18 (e) ~~An~~ A health insurer that pays a commission, fee, or other compensation,
19 directly or indirectly, to a licensed or unlicensed agent, broker, or other
20 individual other than a bona fide employee of the health insurer in connection
21 with the sale of a group insurance policy shall clearly disclose to the purchaser

1 of ~~such group~~ the policy the amount of any such commission, fee, or
2 compensation paid or to be paid.

3 § 4023. PROVISIONS APPLYING TO POLICIES DELIVERED IN
4 ANOTHER STATE (formerly § 4064)

5 If any policy is issued by ~~an~~ a health insurer domiciled in this State for
6 delivery to a person residing in another state, and if the official having
7 responsibility for the administration of the insurance laws of ~~such~~ the other
8 state ~~shall have advised~~ informs the Commissioner that ~~any such~~ the policy is
9 not subject to approval or disapproval by ~~such~~ the official, the Commissioner
10 may ~~by ruling require~~ issue an order requiring that ~~such~~ the policy meet the
11 standards set forth in sections ~~4065, 4066, and 4067~~ 4029, 4030, and 4031 of
12 this title.

13 § 4024. COORDINATION OF INSURANCE COVERAGE WITH
14 MEDICAID AND COMPLIANCE WITH MEDICAID RECOVERY
15 PROVISIONS (formerly § 4062e and § 4080d)

16 (a) ~~Any insurer as defined in section 4100b of this title is prohibited from~~
17 ~~considering~~ No health insurer shall consider the availability of or eligibility for
18 medical assistance in this or any other state under ~~42 U.S.C. § 1396a (Section~~
19 ~~1902 of the Social Security Act), herein referred to as~~ Title XIX of the Social
20 Security Act (Medicaid), when considering eligibility for coverage or making

1 payments under its plan for eligible enrollees, subscribers, policyholders, or
2 certificate holders.

3 (b) A health insurer ~~as defined in 33 V.S.A. § 1900~~ that issues, sells,
4 renews, or offers health insurance coverage in Vermont or who is required to
5 be licensed or registered with the Department shall comply with the
6 requirements of 33 V.S.A. §§ 1907, 1908, 1909, and 1910. The Commissioner
7 shall enforce such requirements pursuant to ~~his or her~~ the Commissioner's
8 authority under this title.

9 § 4025. HEALTH INSURANCE AND THE BLUEPRINT FOR HEALTH
10 (formerly § 4088h)

11 (a)(1) ~~A health~~ All major medical insurance ~~plan~~ plans shall be offered,
12 issued, and administered consistent with the Blueprint for Health established in
13 18 V.S.A. chapter 13, ~~as determined by the Commissioner.~~

14 (2) ~~As used in this section, "health insurance plan" means any individual~~
15 ~~or group health insurance policy, any hospital or medical service corporation~~
16 ~~or health maintenance organization subscriber contract, or any other health~~
17 ~~benefit plan offered, issued, or renewed for any person in this State by a health~~
18 ~~insurer, as defined in 18 V.S.A. § 9402. The term shall include the health~~
19 ~~benefit plan offered by the State of Vermont to its employees and any health~~
20 ~~benefit plan offered by any agency or instrumentality of the State to its~~
21 ~~employees. The term shall not include benefit plans providing coverage for~~

1 ~~specific disease or other limited benefit coverage unless so directed by the~~
2 ~~Commissioner.~~

3 (b) Health insurers ~~as defined in 18 V.S.A. § 701~~ offering major medical
4 insurance plans shall participate in the Blueprint for Health as specified in 18
5 V.S.A. § 706. ~~In consultation with the Director of the Blueprint for Health and~~
6 ~~the Director of Health Care Reform, the Commissioner may establish~~
7 ~~procedures to exempt or limit the participation of health insurers offering a~~
8 ~~stand-alone dental plan or specific disease or other limited benefit coverage. A~~
9 ~~health insurer shall be exempt from participation if the insurer offers only~~
10 ~~benefit plans which are paid directly to the individual insured or the insured's~~
11 ~~assigned beneficiaries and for which the amount of the benefit is not based~~
12 ~~upon potential medical costs or actual costs incurred.~~

13 Subchapter 2. Policy Forms and Filing Requirements

14 § 4026. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS 15 (formerly § 4062)

16 (a)(1) No policy of health insurance or certificate under a policy filed by ~~an~~
17 ~~insurer offering health insurance as defined in subdivision 3301(a)(2) of this~~
18 ~~title, a nonprofit hospital or medical service corporation, a health maintenance~~
19 ~~organization, or a managed care organization~~ a health insurer and not
20 exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for
21 delivery in this State, nor shall any endorsement, rider, or application that

1 becomes a part of any such policy be used, until a copy of the form and of the
2 rules for the classification of risks has been filed with the Department of
3 Financial Regulation and a copy of the premium rates has been filed with the
4 Green Mountain Care Board; and the Green Mountain Care Board has issued a
5 decision approving, modifying, or disapproving the proposed rate.

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

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

15 (3) The Board shall determine whether a rate is affordable, promotes
16 quality care, promotes access to health care, protects insurer solvency, and is
17 not unjust, unfair, inequitable, misleading, or contrary to the laws of this State.
18 In making this determination, the Board shall consider the analysis and opinion
19 provided by the Department of Financial Regulation pursuant to subdivision
20 (2)(B) of this subsection.

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

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

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

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

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

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

7 (ii) the specialty tier formulary list.

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

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

17 (3)(A) Upon request, in conjunction with a rate filing required by
18 subsection (a) of this section, ~~an~~ a health insurer shall provide to the Board
19 detailed information about the insurer's payments to specific providers, which
20 may include fee schedules, payment methodologies, and other payment
21 information specified by the Board.

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

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

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

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

18 (B) The Board shall provide an electronic mechanism for the public
19 to comment on all rate filings. The Board shall accept public comment on each
20 rate filing from the date on which the Board posts the rate filing on its website
21 pursuant to subdivision (A) of this subdivision (2) until 15 calendar days after

1 the Board posts on its website the analyses and opinions of the Department of
2 Financial Regulation and of the Board's consulting actuary, if any, as required
3 by subsection (d) of this section. The Board shall review and consider the
4 public comments prior to issuing its decision.

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

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

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

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

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

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

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

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

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

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

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

18 (3) issue its decision in writing.

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

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

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

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

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

1 for Medicare ~~supplemental~~ supplement insurance policies shall be governed by
2 ~~sections 4062b and 4080e~~ section 4051 of this title.

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

1 ~~(3) [Repealed.]~~

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

7 § 4027. FILING FEES (formerly § 4062a; updated cross-reference only)

8 Each filing of a policy, contract, or document form or premium rates or
9 rules, submitted pursuant to section ~~4062~~ 4026 of this title, shall be
10 accompanied by payment to the Commissioner or the Green Mountain Care
11 Board, as appropriate, of a nonrefundable fee of \$150.00.

12 § 4028. FORM AND CONTENTS OF POLICY (formerly § 4063)

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

16 (1) ~~the entire money~~ The policy sets forth all of the monetary and other
17 considerations ~~therefor for the policy are expressed therein;~~

18 (2) The policy sets forth the time at which the insurance takes effect and
19 terminates ~~is expressed therein;~~

20 (3) ~~it~~ The policy purports to insure only one person, except that a policy
21 may insure, originally or by subsequent amendment, upon the application of an

1 adult member of a family who shall be deemed the policyholder, any two or
2 more eligible members of that family, including ~~husband, wife~~ a spouse or
3 civil union partner, dependent children or any children under a specified age
4 ~~which that~~ shall not exceed 19 years, and any other person dependent upon the
5 policyholder;

6 (4) ~~the~~ The style, arrangement, and overall appearance of the policy give
7 no undue prominence to any portion of the text, and ~~unless~~ every printed
8 portion of the text of the policy and of any endorsements or attached papers is
9 plainly printed in light-faced type of a style in general use, the size of which
10 shall be uniform and not less than 10-point with a ~~lower-case~~ lowercase
11 unspaced alphabet length not less than 120-point. As used in this subdivision,
12 ~~(the “text” shall include~~ includes all printed matter except the name and
13 address of the insurer; the name or title of the policy; the brief description, if
14 any; and the captions and subcaptions);

15 (5) ~~the~~ The exceptions and reductions of indemnity are set forth in the
16 policy and, except those ~~which that~~ are set forth in sections ~~4065 and 4066~~
17 4029 and 4030 of this title, are printed, at the insurer’s option, either ~~included~~
18 with the benefit provision to which they apply, or under an appropriate caption
19 such as “EXCEPTIONS,” or “EXCEPTIONS AND REDUCTIONS;”;
20 provided, however, that if an exception or reduction specifically applies only to

1 a particular benefit of the policy, a the statement of ~~such~~ the exception or
2 reduction shall be included with the benefit provision to which it applies;

3 (6) ~~each such~~ Each policy form, including riders and endorsements,
4 ~~shall be~~ is identified by a form number in the lower left-hand corner of the first
5 page ~~thereof~~ of the form;

6 (7) ~~it contains no~~ The policy does not contain any provision purporting
7 to make any portion of the charter, rules, constitution, or bylaws of the health
8 insurer a part of the policy unless ~~such~~ that portion is set forth in full in the
9 policy, except in the case of the incorporation of, or reference to, a statement of
10 rates or classification of risks; or a short-rate table filed with the
11 Commissioner; ~~and~~.

12 (8) ~~there is~~ Either prominently printed on or attached to the first page
13 ~~thereof or is attached thereto~~ of the policy is a notice to the effect that during a
14 period of 30 days ~~from~~ following the date the policy is delivered to persons
15 eligible for Medicare by reason of age, and 10 days ~~from~~ following the date of
16 delivery to all other persons, the policy may be surrendered to the insurer
17 together with a written request for cancellation of the policy, and that in such
18 event, the insurer will refund any premium paid ~~therefor~~, including any policy
19 fees or other charges; provided, however, that this subdivision shall not apply
20 to single premium nonrenewable policies insuring against accident only or
21 medical costs or accidental bodily injury only.

1 § 4029. REQUIRED STANDARD POLICY PROVISIONS (formerly § 4065;
2 changes to lead-in language only, not policy provisions)

3 Except as provided in section ~~4067~~ 4031 of this title, each ~~such~~ health
4 insurance policy delivered or issued for delivery to any person in this State
5 shall contain the provisions specified in this section ~~in the words in which the~~
6 ~~same appear~~ using the language set forth in this section; provided, however,
7 that ~~the~~ a health insurer may, at its option, ~~substitute for one or more of such~~
8 ~~provisions corresponding provisions of different wording~~ substitute different
9 language approved by the Commissioner ~~which are in each instance~~ for one or
10 more provisions, provided the substituted language is not less favorable in any
11 respect to the insured or covered individual ~~the beneficiary~~ than the language
12 used in this section. ~~Such~~ The provisions specified in this section shall be
13 preceded individually by the caption appearing in this section or, at the option
14 of the health insurer, by such appropriate ~~individual or group~~ captions or
15 subcaptions as the Commissioner may approve:

16 (1) ENTIRE CONTRACT; CHANGES: This policy, including the
17 endorsements and the attached papers, if any, constitutes the entire contract of
18 insurance. No change in this policy shall be valid until approved by an
19 executive officer of the insurer and unless such approval be endorsed hereon or
20 attached hereto. No agent has authority to change this policy or to waive any
21 of its provisions.

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

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

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

16 (3) GRACE PERIOD: A grace period of . . . (insert a number not less
17 than “7” for weekly premium policies, “10” for monthly premium policies and
18 “31” for all other policies) days will be granted for the payment of each
19 premium falling due after the first premium, during which grace period the
20 policy shall continue in force.

1 (A policy which contains a cancellation provision may add, at the end of
2 the above provision,
3 subject to the right of the insurer to cancel in accordance with the
4 cancellation provision hereof,

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

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

11 (4) REINSTATEMENT: If any renewal premium be not paid within the
12 time granted the insured for payment, a subsequent acceptance of premium by
13 the insurer or by any agent duly authorized by the insurer to accept such
14 premium, without requiring in connection therewith an application for
15 reinstatement, shall reinstate the policy; provided, however, that if the insurer
16 or such agent requires an application for reinstatement and issues a conditional
17 receipt for the premium tendered, the policy will be reinstated upon approval
18 of such application by the insurer or, lacking such approval, upon the 45th day
19 following the date of such conditional receipt unless the insurer has previously
20 notified the insured in writing of its disapproval of such application. The
21 reinstated policy shall cover only loss resulting from such accidental injury as

1 may be sustained after the date of reinstatement and loss due to such sickness
2 as may begin more than ten days after such date. In all other respects the
3 insured and insurer shall have the same rights thereunder as they had under the
4 policy immediately before the due date of the defaulted premium, subject to
5 any provisions endorsed hereon or attached hereto in connection with the
6 reinstatement. Any premium accepted in connection with a reinstatement shall
7 be applied to a period for which premium has not been previously paid, but not
8 to any period more than sixty days prior to the date of reinstatement.

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

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

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

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

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

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

11 (8) TIME OF PAYMENT OF CLAIMS: Indemnities payable under this
12 policy for any loss other than loss for which this policy provides any periodic
13 payment will be paid immediately upon receipt of due written proof of such
14 loss. Subject to due written proof of loss, all accrued indemnities for loss for
15 which this policy provides periodic payment will be paid (insert period for
16 payment which must not be less frequently than monthly) and any balance
17 remaining unpaid upon the termination of liability will be paid immediately
18 upon receipt of due written proof.

19 (9) PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in
20 accordance with the beneficiary designation and the provisions respecting such
21 payment which may be prescribed herein and effective at the time of payment.

1 If no such designation or provision is then effective, such indemnity shall be
2 payable to the estate of the insured. Any other accrued indemnities unpaid at
3 the insured’s death may, at the option of the insurer, be paid either to such
4 beneficiary or to such estate. All other indemnities will be payable to the
5 insured.

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

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

16 Subject to any written direction of the insured in the application or
17 otherwise all or a portion of any indemnities provided by this policy on
18 account of hospital, nursing, medical, or surgical services may, at the insurer’s
19 option and unless the insured requests otherwise in writing not later than the
20 time of filing proofs of such loss, be paid directly to the hospital or person

1 rendering such services; but it is not required that the service be rendered by a
2 particular hospital or person.)

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

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

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

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

20 § 4030. OPTIONAL STANDARD POLICY PROVISIONS (formerly § 4066;
21 changes to lead-in language only, not policy provisions)

1 Except as provided in section ~~4067~~ 4031 of this title, no ~~such~~ health
2 insurance policy delivered or issued for delivery to any person in this State
3 shall contain provisions respecting the matters set forth ~~below~~ in this section
4 unless ~~such~~ the provisions ~~are in the words in which the same appear~~ use the
5 language set forth in this section; provided, however, that ~~the~~ a health insurer
6 may, at its option, ~~use in lieu of any such provision a corresponding provision~~
7 ~~of different wording~~ substitute different language approved by the
8 Commissioner ~~which~~ for one or more provisions, provided the substituted
9 language is not less favorable in any respect to the insured or covered
10 individual ~~the beneficiary~~ than the language used in this section. Any ~~such~~
11 provision set forth in this section that is contained in the policy shall be
12 preceded individually by the appropriate caption appearing in this section or, at
13 the option of the health insurer, by such appropriate ~~individual or group~~
14 captions or subcaptions as the Commissioner may approve:

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

1 her occupation to one classified by the insurer as less hazardous than that
2 stated in this policy, the insurer, upon receipt of proof of such change of
3 occupation, will reduce the premium rate accordingly, and will return the
4 excess pro rata unearned premium from the date of change of occupation or
5 from the policy anniversary date immediately preceding receipt of such proof,
6 whichever is the more recent. In applying this provision, the classification of
7 occupational risk and the premium rates shall be such as have been last filed by
8 the insurer prior to the occurrence of the loss for which the insurer is liable or
9 prior to date of proof of change in occupation with the state official having
10 supervision of insurance in the state where the insured resided at the time this
11 policy was issued; but if such filing was not required, then the classification of
12 occupational risk and the premium rates shall be those last made effective by
13 the insurer in such state prior to the occurrence of the loss or prior to the date
14 of proof of change in occupation.

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

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

1 (insert maximum limit of indemnity or indemnities) the excess
2 insurance shall be void and all premiums paid for such excess shall be returned
3 to the insured or to his or her estate.

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

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

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

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

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

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

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

1 total monthly amount of benefits payable under all such coverage upon the
2 insured below the sum of \$200.00 or the sum of the monthly benefits specified
3 in such coverages, whichever is the lesser, nor shall it operate to reduce
4 benefits other than those payable for loss of time.

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

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

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

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

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

5 ~~(11) [Repealed.]~~

6 § 4031. OMISSION OF INAPPLICABLE OR INCONSISTENT

7 STANDARD PROVISIONS (formerly § 4067)

8 If any provision of sections ~~4065 and 4066~~ 4029 and 4030 of this title is in
9 whole or in part inapplicable to or inconsistent with the coverage provided by a
10 particular form of policy, the health insurer, with the approval of the
11 Commissioner, shall omit from such policy any inapplicable provision or part
12 of a provision, and shall modify any inconsistent provision or part of the
13 provision in such manner as to make the provision as contained in the policy
14 consistent with the coverage provided by the policy.

15 § 4032. ORDER OF STANDARD POLICY PROVISIONS (formerly § 4068)

16 The provisions ~~which are the subject of~~ specified in sections ~~4065 and 4066~~
17 4029 and 4030 of this title, or any corresponding provisions ~~which are~~ used in
18 lieu ~~thereof in accordance with such~~ of those provisions as permitted by those
19 sections, shall either be printed in the ~~consecutive order of the provisions in~~
20 such same order as the provisions are set forth in those sections or, at the
21 option of the health insurer, any such provision may appear as a unit in any

1 part of the policy, with other provisions to which it may be logically related,
2 provided the resulting policy shall not be in whole or in part unintelligible,
3 uncertain, ambiguous, abstruse, or likely to mislead a person to whom the
4 policy is offered, delivered, or issued.

5 § 4033. DISCRETIONARY CLAUSES PROHIBITED (formerly § 4062f)

6 (a) The purpose of this section is to ensure that health insurance benefits,
7 disability income protection coverage, and life insurance benefits are
8 contractually guaranteed and to avoid the conflict of interest that may occur
9 when the carrier responsible for providing benefits has discretionary authority
10 to decide what benefits are due. Nothing in this section shall be construed to
11 impose any requirement or duty on any person other than a health insurer or ~~an~~
12 a health insurer offering disability income protection coverage or life
13 insurance.

14 (b) As used in this section:

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

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

1 ~~(3)~~ “Health insurer” means ~~an insurance company that provides health~~
2 ~~insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital~~
3 ~~or medical service corporation, a managed care organization, a health~~
4 ~~maintenance organization, and, to the extent permitted under federal law, any~~
5 ~~administrator of an insured, self-insured, or publicly funded health care benefit~~
6 ~~plan offered by a public or private entity; as well as~~ has the same meaning as in
7 section 4021 of this chapter and, as used in this section, also includes entities
8 offering policies for specific disease, accident, injury, hospital indemnity,
9 dental care, disability income, long-term care, and other limited benefit
10 coverage.

11 ~~(4)~~(3) “Life insurance” means a policy, contract, certificate, or
12 agreement that provides life insurance as defined in subdivision 3301(a)(1) of
13 this title.

14 (c) No policy, contract, certificate, or agreement offered or issued in this
15 State by a health insurer to provide, deliver, arrange for, pay for, or reimburse
16 any of the costs of health care services may contain a provision purporting to
17 reserve discretion to the health insurer to interpret the terms of the contract or
18 to provide standards of interpretation or review that are inconsistent with the
19 laws of this State, and ~~on and after July 1, 2012,~~ any such provision in a policy,
20 contract, certificate, or agreement shall be null and void.

1 (d) No policy, contract, certificate, or agreement offered or issued in this
2 State providing for disability income protection coverage may contain a
3 provision purporting to reserve discretion to the insurer to interpret the terms
4 of the contract or to provide standards of interpretation or review that are
5 inconsistent with the laws of this State, and ~~on and after July 1, 2012,~~ any such
6 provision in a policy, contract, certificate, or agreement shall be null and void.

7 (e) No policy, contract, certificate, or agreement of life insurance offered or
8 issued in this State may contain a provision purporting to reserve discretion to
9 the insurer to interpret the terms of the contract or to provide standards of
10 interpretation or review that are inconsistent with the laws of this State, and ~~on~~
11 ~~and after July 1, 2012,~~ any such provision in a policy, contract, certificate, or
12 agreement shall be null and void.

13 § 4034. REQUIREMENTS OF OTHER JURISDICTIONS (formerly § 4070)

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

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

1 § 4035. POLICIES NOT AFFECTED (formerly § 4076)

2 Nothing in sections ~~4063-4075~~ 4018-4020, 4023, 4028-4032, 4034, 4036,
3 and 4037 of this title shall apply to or affect:

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

6 (2) any policy or contract of reinsurance;

7 (3) any blanket or group policy of insurance enumerated in sections
8 ~~4079-4082~~ 4041-4043 and 4052 of this title, except ~~to the extent provided~~
9 ~~therein~~ as otherwise provided in those sections; or

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

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

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

19 § 4036. NONCONFORMING POLICIES (formerly § 4072)

20 (a) ~~No policy provision which is not subject to section 4065 or 4066 of this~~
21 ~~title shall make a policy, or any portion thereof,~~ A health insurance policy shall

1 not contain any provision that makes the policy or any portion of the policy
2 less favorable in any respect to the ~~insured or the beneficiary~~ covered
3 individual than the provisions thereof which are subject to these sections of the
4 policy that are regulated by sections 4029 and 4030 of this title.

5 (b) A policy delivered or issued for delivery to any person in this State in
6 violation of sections ~~4065 and 4066~~ 4029 and 4030 of this title shall be held
7 valid but shall be construed as provided in this chapter. When any provision in
8 a policy ~~subject to~~ regulated by sections ~~4065 and 4066~~ 4029 and 4030 is in
9 conflict with any provision ~~therein~~ of those sections, the rights, duties, and
10 obligations of the health insurer, ~~the insured and the beneficiary~~ the covered
11 individual shall be governed by the provisions of ~~such~~ those sections.

12 § 4037. APPLICATIONS FOR INSURANCE (formerly § 4073)

13 (a)(1) ~~The insured~~ A covered individual shall not be bound by any
14 statement made in an application for a policy unless a copy of ~~such~~ the
15 application is attached to or endorsed on the policy as a part of the policy when
16 issued ~~as a part thereof~~.

17 (2) If ~~any such~~ a policy delivered or issued for delivery to any person in
18 this State ~~shall be~~ is reinstated or renewed, and the ~~insured or the beneficiary~~
19 covered individual or assignee of ~~such~~ the policy ~~shall make~~ makes a written
20 request to the health insurer for a copy of the application, if any, for such
21 reinstatement or renewal, the health insurer shall deliver or mail a copy of the

1 application to the individual making the request within 15 days after the receipt
2 of ~~such~~ the request ~~at its home office or any branch office of the insurer,~~
3 ~~deliver or mail to the person making such request a copy of such application.~~

4 If ~~such copy shall not be so delivered or mailed~~ the health insurer does not
5 deliver or mail the copy within 15 days, the health insurer shall be precluded
6 from introducing ~~such~~ the application as evidence in any action or proceeding
7 based ~~upon~~ on or involving ~~such~~ the policy or its reinstatement or renewal.

8 (b) No alteration of ~~any~~ a written application for ~~any such~~ a policy shall be
9 made by any person other than the applicant without ~~his or her~~ the applicant's
10 written consent, except that insertions may be made by the health insurer, for
11 administrative purposes only, in ~~such manner as to indicate~~ a manner that
12 indicates clearly that ~~such~~ the insertions are not to be ascribed to the applicant.

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

17 § 4038. RULEMAKING ON POLICY FILINGS (formerly § 4071)

18 The Commissioner may ~~make~~ adopt such reasonable rules ~~and regulations~~
19 concerning the procedure for the filing or submission of policies subject to
20 sections ~~4063-4066~~ 4023 and 4028-4030 of this title as are necessary, proper,

1 or advisable ~~to~~ for the administration of these sections. This provision shall
2 not abridge any other authority granted to the Commissioner by law.

3 Subchapter 3. Group Coverage

4 § 4041. GROUP HEALTH INSURANCE POLICIES; DEFINITIONS

5 (formerly § 4079)

6 (a) As used in this section:

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

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

17 (b) Group health insurance is ~~hereby declared to be that a~~ form of health
18 insurance covering that covers one or more persons, with or without their
19 dependents, ~~and that is~~ issued upon the following basis:

20 (1)(A) Under a policy issued to an employer, who ~~shall be~~ is deemed the
21 policyholder, insuring at least one employee of ~~such~~ the employer, for the

1 benefit of persons other than the employer. ~~The term “employees,” as used in~~
2 ~~this section, shall be deemed to include the officers, managers, and employees~~
3 ~~of the employer; the partners, if the employer is a partnership; the officers,~~
4 ~~managers, and employees of subsidiary or affiliated corporations of a~~
5 ~~corporation employer; and the individual proprietors, partners, and employees~~
6 ~~of individuals and firms, the business of which is controlled by the insured~~
7 ~~employer through stock ownership, contract, or otherwise. The term~~
8 ~~“employer,” as used in this section, may be deemed to include any municipal~~
9 ~~or governmental entity or officer, or the appropriate officer for an~~
10 ~~unincorporated town or gore or for the Unified Towns and Gores of Essex~~
11 ~~County, as well as private individuals, partnerships, and corporations.~~

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

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

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

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

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

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

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

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

14 (IV) a constitution and bylaws that provide that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (i) two or more employers;

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

13 or

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

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

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

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

6 § 4042. GROUP INSURANCE POLICIES; REQUIRED POLICY

7 PROVISIONS (formerly § 4080)

8 (a) Terms and conditions. No group health insurance policy shall contain
9 any provision ~~relative~~ relating to notice of claim, proofs of loss, time of
10 payment of claims, or time within which legal action must be brought upon the
11 policy that, in the opinion of the Commissioner, is less favorable to the persons
12 insured than would be permitted by the provisions set forth in section ~~4065~~
13 4029 of this title. In addition, each such policy shall contain in substance the
14 following provisions:

15 (1) A provision that the policy; the application of the policyholder, if
16 ~~such an~~ an application or copy ~~thereof~~ is attached to ~~such the~~ the policy; and the
17 individual applications, if any, submitted by the employees or members in
18 connection with ~~such the~~ the policy ~~by the employees or members~~ shall constitute
19 the entire contract between the parties, and that all statements, in the absence
20 of fraud, made by any applicant or applicants shall be deemed representations
21 and not warranties, and that no such statement shall avoid the insurance or

1 reduce benefits ~~thereunder~~ under the policy unless contained in a written
2 application, of which a copy is attached to the policy.

3 (2) A provision that the health insurer will furnish to the policyholder,
4 for delivery to each employee or member of the insured group, an individual
5 certificate setting forth in summary form a statement of the essential features
6 of the insurance coverage of ~~such~~ the employee or member and to whom
7 benefits ~~thereunder~~ are payable under the policy. If dependents are included in
8 the coverage, only one certificate need be issued for each family unit.

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

12 (4) ~~[Repealed.]~~

13 ~~(5)~~ A provision that the health insurer shall not exclude part-time
14 employees and shall offer the same group health benefits to part-time
15 employees as it offers to the employee groups of which the part-time
16 employees would be members if they were full-time employees. The health
17 insurer shall offer to include the part-time employees as part of the employer's
18 employee group, at the full rate to be paid by the employer and the employee,
19 at a rate prorated between the employer and the employee, or at the employee's
20 expense. ~~Part-time~~ As used in this subdivision, "part-time employee" means
21 any employee who works a minimum of at least ~~17 1/2~~ 17.5 hours per week.

1 (b) Protections for covered individuals.

2 (1) Preexisting condition exclusions. A group insurance policy shall not
3 contain any provision that excludes, restricts, or otherwise limits coverage
4 under the policy for one or more preexisting health conditions.

5 (2) Annual limitations on cost sharing.

6 (A)(i) The annual limitation on cost sharing for self-only coverage
7 for any year shall be the same as the dollar limit established by the federal
8 government for self-only coverage for that year in accordance with 45 C.F.R.
9 § 156.130.

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

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

20 (ii) The annual limitation on cost sharing for other than self-only
21 coverage for any year in which the federal government does not establish an

1 annual limitation on cost sharing shall be twice the dollar limit for self-only
2 coverage described in subdivision (i) of this subdivision (B).

3 (3) Ban on annual and lifetime limits. A group insurance policy shall
4 not establish any annual or lifetime limit on the dollar amount of essential
5 health benefits, as defined in Section 1302(b) of the Patient Protection and
6 Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health
7 Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
8 applicable regulations and federal guidance, for any individual insured under
9 the policy, regardless of whether the services are provided in-network or out-
10 of-network.

11 (4) No cost sharing for preventive services.

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

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

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

20 (iii) with respect to infants, children, and adolescents, evidence-
21 informed preventive care and screenings as set forth in comprehensive

1 guidelines supported by the federal Health Resources and Services
2 Administration; and

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

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

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

15 § 4043. ASSOCIATION HEALTH PLANS (formerly § 4079a)

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

1 (2) No association health plan shall be issued, offered, or renewed in
2 this State to any person other than an association that was formed or could
3 have been formed under the Employee Retirement Income Security Act of
4 1974, 29 U.S.C. § 1001 et. seq., and accompanying U.S. Department of Labor
5 regulations and guidance, in each case, as in effect as of January 19, 2017.

6 (b) The Commissioner shall adopt rules pursuant to 3 V.S.A. chapter 25
7 regulating association health plans in order to protect Vermont consumers and
8 promote the stability of Vermont's health insurance markets, to the extent
9 permitted under federal law, including rules regarding licensure, solvency and
10 reserve requirements, and rating requirements.

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

13 ~~(d)(1) An association health plan that provided coverage for the 2019 plan~~
14 ~~year may be renewed for coverage of existing association employer members~~
15 ~~for subsequent plan years, to the extent permitted under federal law. An~~
16 ~~association health plan that provided coverage for the 2019 plan year shall not~~
17 ~~enroll any new employer members for coverage after the 2019 plan year;~~
18 ~~provided, however, that new employees of existing association employer~~
19 ~~members may enroll in the plan in a subsequent plan year pursuant to an offer~~
20 ~~of coverage from their employer.~~

1 ~~(2) No new association health plans shall be offered or issued for~~
2 ~~coverage in this State for plan years 2020 and after.~~

3 ~~(3) This subsection does not apply to association health plans that were~~
4 ~~formed or could have been formed under the Employee Retirement Income~~
5 ~~Security Act of 1974, 29 U.S.C. § 1901, et. seq., and accompanying U.S.~~
6 ~~Department of Labor regulations and guidance, in each case, as in effect as of~~
7 ~~January 19, 2017.~~

8 Subchapter 4. Continuation and Conversion of

9 Group Health Insurance Policies

10 § 4047a. CONTINUATION OF GROUP (formerly § 4090a)

11 ~~(a) All group health insurance policies, including major medical insurance~~
12 ~~and dental insurance policies, issued by an insurance company or a nonprofit~~
13 ~~hospital or medical service corporation; self-insured group plans; and prepaid~~
14 ~~health insurance plans, delivered or issued for delivery in this State, which~~
15 ~~insure employees or members for dental insurance or hospital and medical~~
16 ~~insurance on an expense incurred, service basis, or prepaid basis, other than~~
17 ~~policies covering specific diseases or accidental injuries only, shall provide~~
18 ~~that any person whose insurance under the group policy would terminate~~
19 ~~because of the occurrence of a qualifying event as defined in subsection (b) of~~
20 ~~this section shall be entitled to continue his or her the person's health insurance~~
21 ~~under that group policy.~~

1 (b) For purposes of this subchapter, “qualifying event” means:

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

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

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

8 (4) death of the covered employee or member.

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

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

13 (2) The person is covered by Medicare.

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

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

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

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

8 § 4047b. CONTINUATION; NOTICE; TERMS (formerly § 4090b)

9 (a) A person electing continuation shall notify the health insurer, or the
10 policyholder, or the contractor, or agent for the group if the policyholder did
11 not contract for the policy directly with the health insurer, of such election in
12 writing within 60 days after receiving notice following the occurrence of a
13 qualifying event pursuant to subsection ~~4090a(e)~~ 4047a(e) of this title. Notice
14 of election to continue under the group policy shall be accompanied by the
15 initial contribution, which shall include payment for the period from the
16 qualifying event through the end of the month in which the election is made.

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

1 § 4047c. TERMINATION OF COVERAGE (formerly § 4090c)

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

4 (1) The date 18 months after the date that insurance under the policy
5 would have terminated due to a qualifying event, as defined in subsection
6 ~~4090a(b)~~ 4047a(b) of this title.

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

9 (3) The person is covered by Medicare.

10 (4) The person is covered by any other group insured or uninsured
11 arrangement that provides dental coverage or hospital and medical coverage
12 for individuals in a group, under which the person was not covered
13 immediately prior to the occurrence of a qualifying event, as defined in
14 subsection ~~4090a(b)~~ 4047a(b) of this title, and no preexisting condition
15 exclusion applies; provided, however, that the person shall remain eligible for
16 continuation coverages ~~which~~ that are not available under the insured or
17 uninsured arrangement.

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

1 (A) the person shall have the right to become covered under that
2 replacement policy; for the balance of the period that ~~he or she~~ the person
3 would have remained covered under the prior group policy;

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

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

10 § 4047d. RIGHT OF CONVERSION (formerly § 4090d)

11 ~~All group health insurance policies, issued by an insurance company, a
12 nonprofit hospital or medical service corporation, a self-insured group plan,
13 and prepaid health insurance plans delivered or issued for delivery in this State
14 which insure employees or members for hospital and medical insurance on an
15 expense incurred, service or prepaid basis, other than for specific diseases or
16 for accidental injuries only, shall provide that any person whose insurance
17 under the group policy would terminate because of the death or loss of
18 employment of the employee or member shall be entitled to have a converted
19 policy issued to him or her by the insurer under whose group policy he or she
20 was insured, without evidence of insurability.~~

21 § 4047e. CONVERSION; NOTICE; TERMS (formerly § 4090e)

1 ~~(a) Written application and the first premium payment for the converted~~
2 ~~policy shall be made to the insurer not later than 30 days prior to the date~~
3 ~~termination of the continuation of the group policy under section 4090a of this~~
4 ~~title would have occurred due to the death or termination of the employee or~~
5 ~~member. Its effective date shall be the day following the termination of the~~
6 ~~continued insurance under the group policy under subdivision 4090c(1) of this~~
7 ~~title.~~

8 ~~(b) The premium for the converted policy shall be determined in~~
9 ~~accordance with the insurer's table of premium rates applicable to the age and~~
10 ~~class of risk of each person to be covered under that policy and to the type and~~
11 ~~amount of insurance provided.~~

12 ~~(c) The converted policy shall cover any person who was covered by the~~
13 ~~continued group policy. At the option of the insurer, a separate converted~~
14 ~~policy may be issued to cover any dependent. Qualified beneficiaries could be~~
15 ~~charged premiums up to 102 percent of the group rate.~~

16 ~~(d) The converted policy shall not exclude as a preexisting condition any~~
17 ~~condition covered by the group policy.~~

18 ~~(e) The converted policy may provide:~~

19 ~~(1) for a reduction of its hospital and medical benefits by the amount of~~
20 ~~any such benefits payable under the group policy;~~

1 ~~(2) that during the first policy year, the benefits payable under the~~
2 ~~converted policy, together with the benefits payable under the group policy,~~
3 ~~shall not exceed those that would have been payable had the person's~~
4 ~~insurance under the group policy remained in force and effect.~~

5 ~~(f) The insurer may elect to provide group insurance coverage in lieu of the~~
6 ~~issuance of a converted individual policy.~~

7 ~~§ 4047f. EXEMPTIONS; TERMINATION (formerly § 4090f)~~

8 ~~(a) The insurer shall not be required to issue a converted policy if:~~

9 ~~(1) termination under the group policy occurred because the person:~~

10 ~~(A) was not entitled to continuation of group coverage under section~~
11 ~~4090a of this title; or~~

12 ~~(B) failed to elect continuation as provided in section 4090b of this~~
13 ~~title;~~

14 ~~(2) the person is or could be covered by Medicare;~~

15 ~~(3) the person is covered for similar benefits by another individual~~
16 ~~policy; or~~

17 ~~(4) the person is or could be covered for similar benefits under any~~
18 ~~arrangement of coverage for individuals in a group, whether insured or~~
19 ~~uninsured or similar benefits are provided for or available to such person, by~~
20 ~~reason of any state or federal law and together with the converted policy's~~

1 ~~benefits, would result in overinsurance according to the insurer's standards for~~
2 ~~overinsurance.~~

3 ~~(b) The converted policy may provide that as of any premium due date the~~
4 ~~insurer may refuse to renew or to cancel the policy if the person:~~

5 ~~(1) would be overinsured or the person fails to provide the insurer with~~
6 ~~information upon which it can make a determination as to overinsurance;~~

7 ~~(2) would be eligible for coverage under Medicare or under any other~~
8 ~~state or federal law providing for benefits similar to those provided by the~~
9 ~~converted policy; or~~

10 ~~(3) is in default of any required contribution.~~

11 ~~(c) Notice of the conversion privilege shall be included in each certificate~~
12 ~~of coverage.~~

13 ~~§ 4047g. OPTIONS REQUIRED (formerly § 4090g)~~

14 ~~(a) If the group policy from which conversion is made provides basic~~
15 ~~hospital and medical insurance, the person shall be entitled to obtain a~~
16 ~~converted policy providing, at his or her option, coverage similar to the~~
17 ~~coverage provided by the group policy or lesser coverage at lesser premiums.~~

18 ~~(b) If the group policy from which conversion is made provides major~~
19 ~~medical expense insurance, the person shall be entitled to obtain a converted~~
20 ~~policy providing at his or her option, coverage similar to the catastrophic or~~

1 ~~major medical coverage provided by the group policy or lesser coverage at~~
2 ~~lesser premiums.~~

3 ~~(e) If any insurer customarily offers individual policies on a service basis,~~
4 ~~that insurer may, in lieu of converted policies on an expense incurred basis,~~
5 ~~make available converted policies on a service basis which, in the opinion of~~
6 ~~the Commissioner of Financial, satisfy the intent of this subchapter.~~

7 ~~(d) The Commissioner of Financial Regulation may adopt rules describing~~
8 ~~the lesser coverages that may be offered under this section.~~

9 Subchapter 5. Group Health Insurance Termination and Replacement

10 § 4048a. DEFINITIONS; POLICIES AND CONTRACTS COVERED

11 (formerly §§ 4091a and 4091b)

12 (a) As used in this subchapter:

13 (1) ~~“Carrier” means an insurance company, a nonprofit medical or~~
14 ~~hospital service corporation, or a health maintenance organization which issues~~
15 ~~or provides a group health insurance policy or subscriber contract.~~

16 (2) “Group health insurance policy or subscriber contract” means a
17 policy or contract ~~which~~ that meets the following conditions:

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

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

4 (C) there are arrangements for bulk payment of premiums or
5 subscription charges to the ~~insurer, nonprofit service corporation, or health~~
6 ~~maintenance organization~~ health insurer; and

7 (D) there is sponsorship of the plan by the employer, organization, or
8 group.

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

13 § 4048b. TERMINATION FOR NONPAYMENT OF PREMIUM OR
14 SUBSCRIPTION CHARGES (formerly § 4091c)

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

20 (b) If the actions of the ~~carrier~~ health insurer after the end of the grace
21 period indicate that it considers the policy or contract to be continuing in force

1 beyond the end of the grace period, including actions such as continuing to
2 recognize claims subsequently incurred, ~~or in some other manner~~, the ~~carrier~~
3 health insurer shall be liable for valid claims for losses incurred prior to the
4 effective date of written notice of termination to the policyholder or other
5 entity responsible for making payments or submitting subscription charges to
6 the ~~carrier~~ health insurer.

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

12 § 4048c. NOTICE OF TERMINATION (formerly § 4091d)

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

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

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

6 (b) The ~~carrier~~ health insurer giving notice of termination shall prepare and
7 furnish to the policyholder or other entity at the time of notice a supply of a
8 notice form to be distributed to covered employees or members. The form
9 shall state the fact of termination and the effective date of termination. The
10 form shall contain a statement directing employees or members to refer to their
11 certificates or contracts in order to determine their rights.

12 ~~(c) The provisions of this section shall not be construed to relieve any~~
13 ~~nonprofit medical or hospital service corporation of its obligation to notify~~
14 ~~subscribers directly of a termination under this subchapter.~~

15 § 4048d. EXTENSION OF BENEFITS (formerly § 4091e)

16 (a) ~~Every~~ Each group health insurance policy or subscriber contract ~~issued~~
17 ~~on or after July 1, 1989, or under which the level of benefits is altered,~~
18 ~~modified, or amended on or after July 1, 1989,~~ shall provide a reasonable
19 extension of benefits in the event of that the employer or member is in a
20 condition of total disability of the employee or member on the date of

1 termination of the group policy or contract in accordance with the provisions
2 of this section.

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

7 (c) A policy or contract providing hospital or medical expense coverage
8 benefits shall provide an extension of benefits of at least 12 months under
9 ~~“major medical” and “comprehensive medical” type coverages;~~ major medical
10 insurance coverage and at least 90 days under other types of hospital or
11 medical expense ~~coverages~~ coverage.

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

17 (e) ~~The provisions of this section do not~~ Nothing in this section shall be
18 construed to require an extension of dental benefits.

19 § 4048e. REPLACEMENT COVERAGE (formerly § 4091f)

20 (a) General. When the group health insurance policy or subscriber contract
21 of a ~~carrier~~ health insurer replaces a policy or contract providing similar

1 benefits of another ~~carrier~~ health insurer, the liability of both ~~carriers~~ health
2 insurers shall be as provided in this section and rules adopted pursuant to this
3 section.

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

7 (c) Liability of succeeding ~~carrier~~ health insurer.

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

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

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

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

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

1 (4) When replacing a prior ~~earlier's~~ health insurer's plan that is not
2 subject to section ~~4091e~~ 4048d of this title, the succeeding ~~earlier~~ health
3 insurer shall, in addition to the coverage required to be offered under
4 subdivision (2) of this subsection, offer a policy or contract that provides a
5 level of benefit equal to the lesser of:

6 (A) the extension of benefits that would have been required if the
7 prior ~~earlier's~~ health insurer's policy or contract was subject to section ~~4091e~~
8 4048d of this title; or

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

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

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

19 (B) the benefits of the prior ~~earlier's~~ health insurer's policy or
20 contract.

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

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

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

10 Subchapter 6. Other Forms of Health Coverage

11 § 4051. MEDICARE SUPPLEMENTAL HEALTH INSURANCE

12 POLICIES; COMMUNITY RATING; DISABILITY (formerly

13 §§ 4080e and 4062b)

14 (a) Community rating.

15 (1) A health ~~insurance company, hospital or medical service~~
16 ~~corporation, or health maintenance organization~~ insurer shall use a community
17 rating method acceptable to the Commissioner for determining premiums for
18 Medicare ~~supplemental~~ supplement insurance policies.

19 ~~(b)(2)~~ (2) The Commissioner shall adopt rules for standards and procedure for
20 permitting health ~~insurance companies, hospital or medical service~~
21 ~~organizations, or health maintenance organizations~~ insurers that issue Medicare

1 ~~supplemental~~ supplement insurance policies to use one or more risk
2 classifications in their community rating method. The premium charged shall
3 not deviate from the community rate and the rules shall not permit medical
4 underwriting and screening, except that a health ~~insurance company, hospital~~
5 ~~or medical service corporation, or health maintenance organization~~ insurer may
6 set different community rates for persons eligible for Medicare by reason of
7 age and persons eligible for Medicare by reason of disability.

8 ~~(a)~~(b) Premium increases.

9 (1) Within five days ~~of~~ after receiving a request for approval of any
10 composite average rate increase in excess of three percent, or any other
11 coverage changes ~~which~~ that the Commissioner determines will have a
12 comparable impact on cost or availability of coverage for a Medicare
13 ~~supplemental~~ supplement insurance policy issued by any ~~group or nongroup~~
14 ~~health insurance company, hospital or medical service organization, or health~~
15 ~~maintenance organization,~~ health insurer with 5,000 or more total lives in the
16 Vermont Medicare supplement insurance market, the Commissioner shall
17 notify the Department of Disabilities, Aging, and Independent Living of the
18 proposed premium increase. A composite average rate is the enrollment-
19 weighted average rate increase of all plans offered by a ~~carrier~~ health insurer.

20 ~~(b)~~(2) Within five days after receiving notification pursuant to ~~subsection~~
21 ~~(a) of this section~~ subdivision (1) of this subsection, the Department of

1 Disabilities, Aging, and Independent Living shall inform the members of the
2 Advisory Board established pursuant to 33 V.S.A. § 505 of the proposed
3 premium increase.

4 ~~(e)(1)(3)(A)~~ The Commissioner shall not approve any request to increase
5 Medicare ~~supplemental~~ supplement insurance premium rates unless the amount
6 of the rate increase complies with the statutory standards for approval under
7 sections ~~4062~~ 4026, 4513, 4584, and 5104 of this title. Any approved rate
8 increase shall not be based on an unreasonable change in loss ratio from the
9 previous year, unless the Commissioner makes written findings that such
10 change is necessary to prevent a substantial adverse impact on the financial
11 condition of the health insurer. In acting on such rate increase requests, the
12 Commissioner may deny the request, approve the rate increase as requested, or
13 approve a rate increase in an amount different from the increase requested. A
14 decision by the Commissioner other than an approval of the rate requested may
15 be appealed by the health insurer, provided that the burden of proof shall be on
16 the health insurer to show that the approved rate does not meet the statutory
17 standards established under this subsection.

18 ~~(2)(B)~~ Before acting on the rate increase requested, the Commissioner
19 may make such examination or investigation as ~~he or she~~ the Commissioner
20 deems necessary, including where applicable the review process set forth in
21 subdivision ~~(3) of this subsection~~ (C) of this subdivision (3).

1 ~~(3)~~(C)(i) In reviewing any Medicare supplement insurance rate increase
2 for which an independent analysis has been performed pursuant to 33 V.S.A. §
3 6706 and ~~wherein~~ in which the ~~carrier's~~ health insurer's requested composite
4 average increase, the independent expert's recommended composite average
5 rate increase, or the Department actuary's recommended composite average
6 rate increase differ by two percentage points or more, the Commissioner shall
7 hold a public hearing ~~where~~ at which the health insurer, the Department's
8 actuary, the independent expert, any intervenor, and the public will have the
9 opportunity to present written and oral testimony and will be available to
10 answer questions of the Commissioner and those present.

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

15 (iii) If the carrier's requested composite average increase, the
16 independent expert's recommended composite average increase, or the
17 Department actuary's recommended composite average increase differs by less
18 than two percentage points, the Department and the parties shall confer by
19 conference call, or by any other available media, to review the rate requests
20 and recommendations. However, a public hearing may be held at the
21 Commissioner's discretion for good cause shown.

1 ~~(4)~~(D)(i) In any review held in accordance with this ~~subsection~~
2 subdivision (3), the Commissioner shall permit intervention by any person ~~that~~
3 whom the Commissioner determines will materially advance the interests of
4 the ~~insured~~ covered individuals. The intervenor shall have access to, and may
5 use the information of the independent expert appointed under 33 V.S.A. §
6 6706.

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

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

16 (c) Disability.

17 (1) A health ~~insurance company, hospital or medical service~~
18 ~~corporation, or health maintenance organization~~ insurer that issues Medicare
19 ~~supplemental~~ supplement insurance policies or certificates to a person eligible
20 for Medicare by reason of age shall make available, to persons eligible for
21 Medicare by reason of disability, the same policies or certificates that are

1 offered and sold to persons eligible for Medicare by reason of age. ~~This~~
2 ~~subsection does not apply to persons eligible for Medicare by reason of end~~
3 ~~stage renal disease.~~ The initial enrollment period for any such policies or
4 certificates shall be at least six months following the date the individual
5 becomes eligible for Medicare by reason of disability. Any additional
6 enrollment periods as required by law and offered to individuals eligible by
7 reason of age shall be offered to individuals eligible by reason of disability.

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

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

17 § 4052. BLANKET HEALTH INSURANCE (formerly §§ 4081 and 4082)

18 (a) Blanket health insurance is ~~hereby declared to be that~~ a form of health
19 insurance ~~which that,~~ to the extent permitted under federal law, is supplemental
20 to ~~comprehensive~~ major medical health insurance; or ~~which~~ provides coverage
21 other than the payment of all or a portion of the cost of health care services or

1 products, and ~~covering~~ that covers special groups of persons ~~set forth~~ as
2 follows:

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

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

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

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

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

5 ~~(a)~~(b)(1) No ~~such~~ blanket health insurance policy shall contain any
6 provision ~~relative~~ relating to notice of claim, proofs of loss, time of payment of
7 claims, or time within which legal action must be brought upon the policy
8 ~~which~~ that, in the opinion of the Commissioner, is less favorable to the persons
9 insured than would be permitted by the provisions set forth in section ~~4065~~
10 4029 of this title.

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

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

1 (4) Nothing ~~contained~~ in this section ~~or section 4081 of this title~~ shall be
2 deemed to affect the legal liability of policyholders for the death of, or injury
3 to, any ~~such~~ members of ~~such~~ the group.

4 ~~(b)(c)~~ No ~~such~~ blanket health insurance policy ~~which~~ that provides
5 coverage for the payment of all or a portion of the cost of health care services
6 or products shall contain any provision ~~not in compliance~~ that does not comply
7 with a requirement of this title, or a rule adopted pursuant to this title
8 applicable to health insurance, other than those requirements applicable to
9 nongroup health insurance or small group health insurance. The
10 Commissioner may waive the application to a blanket insurance policy of one
11 or more of the health insurance requirements of this title, or a rule adopted
12 pursuant to this title, if ~~such~~ the requirement is not relevant to the types of risks
13 and duration of risks insured against in ~~such~~ the blanket insurance policy.

14 § 4053. SHORT-TERM, LIMITED-DURATION HEALTH INSURANCE
15 (formerly § 4084a)

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

1 (b) ~~An insurer shall not~~ No person shall provide short-term, limited-
2 duration health insurance coverage ~~unless the insurer has~~ without a certificate
3 of authority from the Commissioner to offer health insurance in this State as
4 ~~defined in subdivision 3301(a)(2) of this title or is licensed or registered with~~
5 ~~the Commissioner as a nonprofit hospital or medical service corporation,~~
6 ~~health maintenance organization, or managed care organization,~~ unless the
7 ~~insurer~~ person is exempted by subdivision 3368(a)(4) of this title.

8 (c) A short-term, limited-duration health insurance policy or contract shall
9 be nonrenewable, and ~~an~~ a health insurer shall not issue a short-term, limited-
10 duration health insurance policy or contract to any person if the issuance would
11 result in the person being covered by short-term, limited-duration health
12 insurance coverage for more than three months in any 12-month period.

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

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

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

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

8 (3) requiring ~~an~~ a health insurer seeking to provide short-term, limited-
9 duration health insurance coverage to individuals in this State to file its
10 advertising materials with the Commissioner for ~~his or her~~ the Commissioner's
11 approval; and

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

15 (f) The provisions of section ~~4089f~~ 4063 of this title, and any rules adopted
16 under that section, shall apply to short-term, limited-duration health insurance
17 coverage.

18 Subchapter 7. Child and Dependent Coverage

19 § 4057. COVERAGE OF CHILDREN (formerly §§ 4089d, 4092, 4100b(c),
20 4100c, 4100d)

1 (a) Definition. ~~As used in this section, “health insurance plan” has the~~
2 ~~same meaning as “group health plan” and “Health insurance plan” has the~~
3 ~~same meaning as in section 4011 of this chapter and~~ shall be subject to the
4 same excepted benefits, in each case, as set forth in 45 C.F.R. § 146.145, as in
5 effect as of December 31, 2017.

6 (b) Newborn coverage.

7 ~~(a)(1) An individual or group health insurance policy providing coverage~~
8 ~~on an expense incurred basis and an individual or group service or indemnity~~
9 ~~contract issued by a nonprofit corporation which provides coverage for a~~
10 ~~family member of the insured or subscriber shall, as to those family members²~~
11 ~~coverage, A health insurance plan that provides dependent coverage of~~
12 children shall also provide that health insurance benefits applicable ~~for~~ to
13 children are payable with respect to a newly born child of the insured or
14 subscriber from the moment of birth. Coverage for a newly born child shall
15 include coverage of injury, sickness, and necessary care and treatment of
16 medically diagnosed congenital defect or birth abnormality, ~~or any~~
17 ~~combination of these.~~

18 ~~(b)(2)~~ Coverage for a newly born child shall be provided without notice or
19 additional premium for ~~no~~ not less than 60 days after the date of birth. If
20 payment of a specific premium or subscription fee is required in order to have
21 the coverage continue beyond such 60-day period, the policy may require that

1 notification of the birth of the newly born child and payment of the required
2 premium or fees be furnished to the ~~insurer or nonprofit service or indemnity~~
3 ~~corporation~~ health insurer within a period of not less than 60 days after the date
4 of birth.

5 ~~(e) The requirements of this section shall apply to all insurance policies and~~
6 ~~subscriber contracts delivered or issued for delivery in this State more than 120~~
7 ~~days after April 15, 1975.~~

8 (c) Adopted child coverage.

9 ~~(a)(1)~~ As used in this section:

10 ~~(1)(A)~~ “Child” means, in connection with any adoption, or placement
11 for adoption of the child, an individual who has not attained ~~age~~ 18 years of
12 age as of the date of the adoption or placement for adoption.

13 ~~(2)(B)~~ “Placement for adoption” means the assumption and retention by
14 a person of a legal obligation for total or partial support of a child in
15 anticipation of the adoption of the child. The child’s placement with a person
16 terminates upon the termination of such legal obligations.

17 ~~(b)(2)~~ In any case in which a health insurance plan provides coverage for
18 dependent children of participants or beneficiaries, the plan shall provide
19 benefits to dependent children placed with participants or beneficiaries for
20 adoption under the same terms and conditions as apply to the natural,

1 dependent children of the participants and beneficiaries, irrespective of
2 whether the adoption has become final.

3 ~~(e)~~(3) A health insurance plan ~~may~~ shall not restrict coverage under the
4 plan of any dependent child adopted by a ~~participant or beneficiary~~ covered
5 individual, or placed with a ~~participant or beneficiary~~ covered individual for
6 adoption, solely on the basis of a preexisting condition of the child at the time
7 that the child would otherwise become eligible for coverage under the plan, if
8 the adoption or placement for adoption occurs while the ~~participant or~~
9 ~~beneficiary~~ covered individual is eligible for coverage under the plan.

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

17 (e) Coverage of adult child with a disability.

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

1 (A) is incapable of self-sustaining employment by reason of a mental
2 or physical disability that has been found to be a disability that qualifies or
3 would qualify the child for benefits using the definitions, standards, and
4 methodology in 20 C.F.R. Part 404, Subpart P;

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

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

8 (2) Coverage under subdivision (1) of this subsection shall not be denied
9 any person based upon the existence of such a condition; provided, however,
10 that a health insurance plan may require reasonable periodic proof of a
11 continuing condition no more frequently than once every year.

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

1 plans, the health plan administrator. The health insurance plan may require
2 reasonable periodic proof from the student's treating ~~physician~~ health care
3 professional that the leave of absence continues to be medically necessary.

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

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

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

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

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

20 § 4058. MEDICAL SUPPORT ORDERS (formerly § 4100b but without
21 subsec. (c), which moved to new § 4057)

1 (a) As used in this ~~subchapter~~ section:

2 (1) ~~“Health plan” shall include a group health plan as defined under~~
3 ~~Section 607(1) of the Employee Retirement Income Security Act of 1974 and a~~
4 ~~nongroup plan as defined in section 4080b of this title.~~

5 (2) ~~“Insurer” shall include any entity providing health insurance or a~~
6 ~~health plan, a health maintenance organization as defined in subdivision~~
7 ~~5101(2) of this title, or a hospital or medical service corporation as defined in~~
8 ~~chapters 123 and 125 of this title.~~

9 (3)(1) “Dependent coverage” means family coverage, or coverage for
10 one or more persons as long as the coverage for one or more persons is greater
11 than or equal to the coverage available under family coverage.

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

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

18 (1) the child was born ~~out of wedlock~~ to unmarried parents;

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

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

3 (c) ~~Where a child has health coverage through an insurer of a parent, the~~
4 ~~insurer shall:~~

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

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

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

17 ~~(d) Where~~ When a parent is required by a court or administrative order to
18 provide health coverage for a child, and the parent is eligible for dependent
19 health coverage, the health insurer shall be required:

20 (1) To enroll, under the dependent coverage, a child who is otherwise
21 eligible for the coverage without regard to any enrollment season restrictions

1 or any seasonal restrictions on switching from one plan to another, upon
2 application of either parent, the employer, the State agency administering the
3 Medicaid program, any State agency administering health benefits or a health
4 ~~benefit~~ insurance plan for which Medicaid is a source of funding, or the child
5 support enforcement program.

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

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

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

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

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

20 ~~(e)(d)~~ ~~An~~ A health insurer ~~may~~ shall not impose requirements on a State
21 agency, ~~which~~ that has been assigned the rights of an individual eligible for

1 medical assistance under Medicaid and covered for health benefits from the
2 health insurer; that are different from requirements applicable to an agent or
3 assignee of any other individual so covered.

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

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

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

21 § 4059. COVERAGE FOR CIVIL UNIONS (formerly § 4063a – updates)

1 (a) As used in this section:

2 (1) “Dependent coverage” means family coverage or coverage for one
3 or more persons.

4 (2) “Party to a civil union” ~~is defined for purposes of this section as~~
5 under has the same meaning as in 15 V.S.A. § 1201.

6 ~~(3) “Insurer” shall mean a health insurer as defined in 18 V.S.A. § 9402.~~

7 (b) Notwithstanding any provision of law to the contrary, health insurers
8 shall provide dependent coverage to parties to a civil union that is equivalent to
9 that provided to covered individuals who are married insureds. ~~An individual~~
10 ~~or group~~ A health insurance policy ~~which that~~ provides coverage for a spouse
11 or family member of the ~~insured~~ covered individual shall also provide the
12 equivalent coverage for a party to a civil union.

13 § 4060. COVERAGE FOR EMPLOYEES OF AN EMPLOYER

14 DOMICILED OUTSIDE VERMONT (formerly § 4063b – updates)

15 (a) As used in this section:

16 (1) ~~“Health insurance” shall have the same meaning as “group health~~
17 ~~insurance policy or subscriber contract” in section 4091a of this title.~~

18 ~~(2) “Marriage” shall have~~ has the same meaning as in 15 V.S.A. § 8.

19 ~~(3)~~(2) “Party to a civil union” ~~shall have~~ has the same meaning as in 15
20 V.S.A. § 1201.

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

5 Subchapter 8. Internal and External Reviews

6 § 4063. INDEPENDENT EXTERNAL REVIEW OF HEALTH CARE

7 SERVICE DECISIONS (formerly § 4089f – updates)

8 (a) As used in this section:

9 (1) ~~“Health benefit plan” means a policy, contract, certificate, or~~
10 ~~agreement entered into, offered, or issued by a health insurer, as defined in 18~~
11 ~~V.S.A. § 9402, to provide, deliver, arrange for, pay for, or reimburse any of the~~
12 ~~costs of health care services.~~

13 (2) ~~“Insured” means the beneficiary of a health benefit insurance plan,~~
14 ~~including the subscriber and all others covered under the plan, and shall also~~
15 ~~mean, “covered individual” includes a member of a health benefit insurance~~
16 ~~plan not otherwise subject to the Department’s jurisdiction that has voluntarily~~
17 ~~agreed to use the external review process provided under this section.~~

18 (b) ~~An insured~~ A covered individual who has exhausted all applicable
19 internal review procedures provided by the health ~~benefit~~ insurance plan shall
20 have the right to an independent external review of a decision under a health
21 ~~benefit~~ insurance plan to deny, reduce, or terminate health care coverage or to

1 deny payment for a health care service. The independent review shall be
2 available when requested in writing by the affected ~~insured~~ covered individual,
3 provided the decision to be reviewed requires the plan to expend at least
4 \$100.00 for the service and the decision by the plan is based on one of the
5 following reasons:

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

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

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

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

1 (5) The decision involves an adverse determination related to surprise
2 medical billing, as established under Section 2799A-1 or 2799A-2 of the
3 Public Health Service Act, including with respect to whether an item or service
4 that is the subject of the adverse determination is an item or service to which
5 Section 2799A-1 or 2799A-2 of the Public Health Service Act, or both,
6 applies.

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

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

12 (1) The independent external reviews shall be conducted:

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

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

1 (2) ~~An insured~~ A covered individual shall:

2 (A) Be provided with adequate notice of ~~his or her~~ the covered
3 individual's review rights under this section.

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

6 (C) Pay an application fee of \$25.00 for each request for an
7 independent external review of an appealable decision not to exceed a total of
8 \$75.00 annually. The application fee may be waived or reduced based on a
9 determination by the Commissioner that the financial circumstances of the
10 ~~insured~~ covered individual warrant a waiver or reduction. The application fee
11 shall be paid by the health insurer, not the ~~insured~~ covered individual, if the
12 independent review organization reverses ~~an~~ the health insurer's decision to
13 deny payment for a health care service.

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

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

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

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

4 (6) The records of, and internal materials prepared for, specific reviews
5 by any independent review organization under this section shall be exempt
6 from public disclosure under 1 V.S.A. § 316 inspection and copying under the
7 Public Records Act.

8 (e) ~~Repealed.~~

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

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

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

16 § 4064. MENTAL HEALTH CARE SERVICES REVIEW (formerly
17 § 4089a)

18 (a) The purposes of this section are to:

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

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

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

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

11 (b) Definitions. As used in this section:

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

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

1 (3) “Mental health ~~care~~ services” mean acts of diagnosis, treatment,
2 evaluation, or advice or any other acts permissible under the health care laws
3 of Vermont, whether performed in an outpatient or institutional setting, and
4 include ~~alcohol and drug abuse~~ treatment for substance use disorder.

5 (4) “Review agent” means a person or entity performing service review
6 activities within one year ~~of~~ following the date of submission of a fully
7 compliant application for licensure who is ~~either~~ affiliated with, under contract
8 with, or acting on behalf of a business entity in this State and who provides or
9 administers mental health ~~care~~ benefits to members of health ~~benefit~~ insurance
10 plans subject to the Department’s jurisdiction, including a health insurer,
11 ~~nonprofit health service plan, health insurance service organization, health~~
12 ~~maintenance organization, or preferred provider organization, including~~
13 ~~organizations that rely upon primary care physicians to coordinate delivery of~~
14 ~~services.~~

15 (5) “Service review” means any system for reviewing the appropriate
16 and efficient allocation of mental health ~~care~~ services given or proposed to be
17 given to a client or patient, or to a group of clients or patients, for the purpose
18 of recommending or determining whether ~~such~~ the services should be
19 ~~reimbursed, covered, or provided by an a health insurer, plan, or other entity or~~
20 ~~person~~ and includes activities of utilization review and managed care, but does

1 not include professional peer review ~~which~~ that does not affect reimbursement
2 for or provision of services.

3 (c) Any person who approves or denies payment, or who recommends
4 approval or denial of payment, for mental health ~~care~~ services, or whose
5 review results in approval or denial of payment for mental health services on a
6 case-by-case basis, ~~may~~ shall not review ~~such~~ these services in this State unless
7 the Commissioner has granted the person a review agent's license. ~~On or~~
8 ~~before January 1, 1995, the~~ The Commissioner shall adopt rules to implement
9 the provisions of this section, including the procedures and standards for
10 licensure. The rules shall differentiate between health maintenance
11 organizations licensed to do business within this State and other forms of
12 utilization review. The rules shall establish:

13 (1) A requirement that within 10 business days after receiving a request
14 for them, the review agent shall make available at no cost to ~~its clients/patients~~
15 the clients, patients, and providers affected by its service review activities; the
16 specific review criteria and standards, credentials of the reviewing
17 professionals, and procedures and methods to be used in evaluating proposed
18 or delivered mental health ~~care~~ services.

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

1 (3) A requirement that any determination regarding mental health care
2 services rendered or to be rendered to a ~~client/patient~~ which client or patient
3 that may result in a denial of third-party reimbursement or a denial of pre-
4 certification for that service shall include the evaluation, findings, and
5 concurrence of a mental health professional whose training and expertise is at
6 least comparable to that of the treating ~~clinician~~ health care professional.

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

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

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

17 (7) A procedure for clients, ~~or~~ patients, ~~or both~~, mental health
18 professionals, ~~or~~ and hospitals to seek prompt reconsideration before an
19 independent review organization pursuant to section ~~4089f~~ 4063 of this title of
20 an adverse decision by a review agent. The external reviewer engaged by the

1 independent review organization shall have training and expertise at least
2 comparable to that of the treating ~~clinician~~ health care professional.

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

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

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

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

17 (C) ~~Notwithstanding the foregoing,~~ A clinical decision made by the
18 attending mental health professional regarding continued treatment shall not be
19 construed as a denial of services subject to the provisions of this section.

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

1 (e) ~~Interim provisions: Review agents who are operating in Vermont prior~~
2 ~~to the adoption of rules pursuant to this section may continue to conduct~~
3 ~~review activities until the Commissioner adopts rules and acts upon the~~
4 ~~application submitted by the review agent. Review agents operating pursuant~~
5 ~~to this subsection shall file a completed initial application within the time set~~
6 ~~forth by rule in order to continue operating until a license is granted.~~

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

12 (g) ~~{Repealed.}~~

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

18 (i) The confidentiality of any health care information acquired by or
19 provided to an independent review organization pursuant to section ~~4089f~~ 4063
20 of this title shall be maintained in compliance with any applicable State or
21 federal laws. Records of, and internal materials prepared for, specific reviews

1 under this section shall be exempt from public inspection and copying under
2 the Public Records Act.

3 Subchapter 9. Required Covered Benefits

4 § 4067. APPLICATION OF SUBCHAPTER (NEW)

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

7 (1) apply only to major medical insurance plans;

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

12 (3) do not apply to Vermont Medicaid.

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

18 § 4068. CHIROPRACTIC SERVICES (formerly § 4088a)

19 ~~(a)(1)~~ A health insurance plan shall provide coverage for clinically
20 necessary health care services provided by a chiropractic physician licensed in
21 this State for treatment within the scope of practice described in 26 V.S.A.

1 chapter 10, but limiting adjunctive therapies to physiotherapy modalities and
2 rehabilitative exercises. A health insurance plan does not have to provide
3 coverage for the treatment of any visceral condition arising from problems or
4 dysfunctions of the abdominal or thoracic organs.

5 ~~(b)(2)~~ A health insurer may require that the chiropractic services be
6 provided by a licensed chiropractic physician under contract with the insurer or
7 upon referral from a health care provider under contract with the health insurer.

8 ~~(3)~~ Health care services provided by chiropractic physicians may be
9 subject to reasonable deductibles, co-payment and coinsurance amounts, fee or
10 benefit limits, practice parameters, and utilization review consistent with any
11 applicable regulations published by the Department of Financial Regulation;
12 provided that any such amounts, limits, and review shall not function to direct
13 treatment in a manner unfairly discriminative against chiropractic care and
14 collectively shall be no more restrictive than those applicable under the same
15 policy to care or services provided by other health care providers but allowing
16 for the management of the benefit consistent with variations in practice
17 patterns and treatment modalities among different types of health care
18 providers.

19 ~~(c)(4)~~ For silver- and bronze-level qualified health benefit plans and any
20 reflective health benefit plans offered at the silver or bronze level pursuant to
21 33 V.S.A. chapter 18, subchapter 1, health care services provided by a

1 chiropractic physician may be subject to a co-payment requirement, provided
2 that any required co-payment amount shall be between 125 and 150 percent of
3 the amount of the co-payment applicable to care and services provided by a
4 primary care provider under the plan.

5 ~~(d)(5)~~ Nothing ~~contained~~ in this section shall be construed as impeding
6 or preventing either the provision or coverage of health care services by
7 licensed chiropractic physicians, within the lawful scope of chiropractic
8 practice, in hospital facilities on a staff or employee basis.

9 ~~(b) As used in this section, “health insurance plan” means any individual or~~
10 ~~group health insurance policy, any hospital or medical service corporation or~~
11 ~~health maintenance organization subscriber contract, or any other health~~
12 ~~benefit plan offered, issued, or renewed for any person in this State by a health~~
13 ~~insurer, as defined by 18 V.S.A. § 9402. The term shall not include benefit~~
14 ~~plans providing coverage for specific disease or other limited benefit coverage.~~

15 § 4069. PROSTHETICS PARITY (formerly § 4088f)

16 (a) As used in this section:

17 ~~(1) “Health insurance plan” means any health insurance policy or health~~
18 ~~benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well~~
19 ~~as Medicaid and any other public health care assistance program offered or~~
20 ~~administered by the State or by any subdivision or instrumentality of the State.~~

1 ~~The term shall not include policies or plans providing coverage for a specific~~
2 ~~disease or other limited benefit coverage.~~

3 (2) ~~Prosthetic~~, “prosthetic device” means an artificial limb device to
4 replace, in whole or in part, an arm or a leg.

5 (b) A health insurance plan shall provide coverage for prosthetic devices ~~in~~
6 ~~all health plans~~ that is at least equivalent to ~~that~~ the coverage provided by the
7 federal Medicare program. Coverage may be limited to the prosthetic device
8 that is the most appropriate model that is medically necessary to meet the
9 patient’s medical needs. Any dispute between the ~~insured~~ covered individual
10 and the carrier concerning coverage and the application of this section shall be
11 subject to independent external review under section ~~4089f~~ 4063 of this title.

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

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

17 (e) ~~A health insurance plan shall not impose any annual or lifetime dollar~~
18 ~~maximum on coverage for prosthetics that is less than the annual or lifetime~~
19 ~~dollar maximum that applies generally to all terms and services covered under~~
20 ~~the plan.~~

1 ~~(f)~~ The coverage ~~required~~ may for prosthetic devices shall not be subject to
2 a deductible, co-payment, or coinsurance provision that is less favorable to a
3 covered individual than the deductible, co-payment, or coinsurance provisions
4 that apply generally to other non-primary care items and services under the
5 health insurance plan.

6 § 4070. HEARING AID COVERAGE IN LARGE GROUP HEALTH

7 INSURANCE PLANS ~~(formerly § 40881)~~

8 (a) As used in this section:

9 (1) ~~“Health insurance plan” means a group health insurance policy or~~
10 ~~health benefit plan offered by a health insurance company, nonprofit hospital~~
11 ~~or medical service corporation, or health maintenance organization, but does~~
12 ~~not include:~~

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

15 ~~(B) a health benefit plan offered by an intermunicipal insurance~~
16 ~~association to one or more entities providing educational services pursuant to~~
17 ~~24 V.S.A. chapter 121, subchapter 6; or~~

18 ~~(C) a policy or plan providing coverage for a specified disease or~~
19 ~~other limited benefit coverage.~~

20 (2) ~~“Hearing aid”~~ means any small, wearable electronic instrument or
21 device designed and intended for the ear for the purpose of aiding or

1 compensating for impaired human hearing and any related parts, attachments,
2 or accessories, including earmolds and associated remote microphones that
3 pair with hearing aids to improve word comprehension in difficult listening
4 situations in live or telecommunication settings. The term does not include
5 large-audience assisted listening devices, such as those designed for
6 auditoriums, or stand-alone assisted listening devices that can function without
7 a hearing aid.

8 ~~(2)~~⁽³⁾ “Hearing aid professional services” means the practice of fitting,
9 selecting, dispensing, selling, or servicing hearing aids, or a combination,
10 including:

- 11 (A) evaluation for a hearing aid;
- 12 (B) fitting of a hearing aid;
- 13 (C) programming of a hearing aid;
- 14 (D) hearing aid repairs;
- 15 (E) follow-up adjustments, servicing, and maintenance of a hearing
16 aid;
- 17 (F) ear mold impressions; and
- 18 (G) auditory rehabilitation and training.

19 ~~(3)~~⁽⁴⁾ “Hearing care professional” means an audiologist or hearing aid
20 dispenser licensed under 26 V.S.A. chapter 67, a physician licensed under 26
21 V.S.A. chapter 23 or 33, a physician assistant licensed under 26 V.S.A. chapter

1 31, or an advanced practice registered nurse licensed under 26 V.S.A. chapter
2 28, working within that professional’s scope of practice.

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

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

8 (B) a health benefit plan offered by an intermunicipal insurance
9 association to one or more entities providing educational services pursuant to
10 24 V.S.A. chapter 121, subchapter 6.

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

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

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

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

6 (d) The coverage required by this section shall not be subject to a
7 deductible, co-payment, or coinsurance provision that is less favorable to a
8 covered individual than the deductible, co-payment, or coinsurance provisions
9 that apply generally to other nonprimary care items and services under the
10 large group health insurance plan.

11 ~~(e) A covered individual who has exhausted all applicable internal review~~
12 ~~procedures provided by the health insurance plan shall have the right to an~~
13 ~~independent external review as set forth in section 4089f of this title.~~

14 § 4071. GENDER-AFFIRMING HEALTH CARE SERVICES (formerly
15 § 4088m)

16 (a) ~~Definitions.~~ As used in this section:

17 (1) ~~“Gender~~ “gender affirming health care services” has the same
18 meaning as in 1 V.S.A. § 150.

19 (2) ~~“Health insurance plan” means Medicaid and any other public health~~
20 ~~care assistance program, any individual or group health insurance policy, any~~
21 ~~hospital or medical service corporation or health maintenance organization~~

1 ~~subscriber contract, or any other health benefit plan offered, issued, or renewed~~
2 ~~for any person in this State by a health insurer as defined by 18 V.S.A. § 9402.~~
3 ~~For purposes of this section, health insurance plan includes any health benefit~~
4 ~~plan offered or administered by the State or any subdivision or instrumentality~~
5 ~~of the State. The term does not include benefit plans providing coverage for a~~
6 ~~specific disease or other limited benefit coverage, except that it includes any~~
7 ~~accident and sickness health plan.~~

8 (b) Coverage.

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

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

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

15 ~~(2) Coverage provided pursuant to this section by Medicaid or any other~~
16 ~~public health care assistance program shall comply with all federal~~
17 ~~requirements imposed by the Centers for Medicare and Medicaid Services.~~

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

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

5 (d) This section shall apply to Medicaid and any other public health care
6 assistance program offered or administered by the State or by any subdivision
7 or instrumentality of the State. The coverage provided pursuant to this section
8 by Medicaid and other public health care assistance programs shall comply
9 with any requirements imposed on such coverage by the Centers for Medicare
10 and Medicaid Services.

11 § 4072. MENTAL HEALTH AND SUBSTANCE USE DISORDER

12 SERVICES (formerly § 4089b)

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

18 (b) As used in this section:

19 (1) ~~“Health insurance plan” means any health insurance policy or health~~
20 ~~benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, except~~
21 ~~a benefit plan providing coverage for a specific disease or other limited benefit~~

1 ~~coverage. Health insurance plan includes any health benefit plan offered or~~
2 ~~administered by the State, or any subdivision or instrumentality of the State.~~

3 (2) “Mental condition” means any condition or disorder involving
4 psychiatric disabilities or ~~alcohol or~~ substance use disorder that falls under any
5 of the diagnostic categories listed in the mental disorders section of the
6 International Classification of Diseases, as periodically revised.

7 (2)(3) “Rate, term, or condition” means any lifetime or annual payment
8 limits, deductibles, copayments, coinsurance, and any other cost-sharing
9 requirements, out-of-pocket limits, visit limits, and any other financial
10 component of health insurance coverage that affects the ~~insured~~ covered
11 individual.

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

14 (1) not establish any rate, term, or condition that places a greater burden
15 on ~~an insured~~ a covered individual for access to treatment for a mental
16 condition than for access to treatment for other health conditions, including no
17 greater co-payment for primary mental health care or services than the co-
18 payment applicable to care or services provided by a primary care provider
19 under ~~an insured’s policy~~ a covered individual’s health insurance plan and no
20 greater co-payment for specialty mental health care or services than the co-

1 payment applicable to care or services provided by a specialist provider under
2 ~~an insured's policy~~ a covered individual's health insurance plan;

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

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

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

17 (d)(1)(A) A health insurance plan that does not otherwise provide for
18 management of care under the plan, or that does not provide for the same
19 degree of management of care for all health conditions, may provide coverage
20 for treatment of mental conditions through a managed care organization,
21 provided that the managed care organization is in compliance with ~~the~~ rules

1 adopted by the Commissioner that ensure that the system for delivery of
2 treatment for mental conditions does not diminish or negate the purpose of this
3 section. In reviewing policy rates and forms pursuant to section ~~4062~~ 4026 of
4 this title, the Commissioner or the Green Mountain Care Board established in
5 18 V.S.A. chapter 220, as appropriate, shall consider the compliance of the
6 policy with the provisions of this section.

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

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

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

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

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

16 (v) in the case of a managed care organization that contracts with
17 a health insurer to administer the health insurer's mental health benefits, the
18 portion of a health insurer's premium rate attributable to the coverage of
19 mental health benefits is reviewed under section ~~4062~~ 4026, 4513, 4584, or
20 5104 of this title to determine whether it is excessive, inadequate, unfairly

1 discriminatory, unjust, unfair, inequitable, misleading, or contrary to the laws
2 of this State;

3 (vi) the health insurance plan is consistent with the Blueprint for
4 Health with respect to mental conditions, ~~as determined by the Commissioner~~
5 ~~under 18 V.S.A. § 9414(b)(2)~~;

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

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

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

17 (viii) an up-to-date list of active mental health ~~care providers~~
18 professionals in the plan's network ~~who are available to the general~~
19 ~~membership~~ is available on the health insurer's and managed care
20 organization's websites and provided to consumers upon request; and

1 (ix) the health insurers and managed care organizations make
2 accessible to consumers the toll-free telephone number for the ~~Vermont Health~~
3 ~~Care Administration's~~ Department of Financial Regulation's consumer
4 protection help line.

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

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

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

13 (iii) establishing benefit design, infrastructure support, and
14 payment methodology standards for evaluating the health insurance plan's
15 consistency with the Blueprint for Health with respect to the care and treatment
16 of mental conditions.

17 (2) A managed care organization providing or administering coverage
18 for treatment of mental conditions on behalf of a health insurance plan shall
19 comply with this section, sections ~~4089a~~ 4064 and 4724 of this title, and 18
20 V.S.A. § 9414₂; with rules adopted pursuant to those provisions of law₂; and
21 with all other obligations, under Title 18 and under this title, of the health

1 insurance plan and the health insurer on behalf of which the ~~review agent~~
2 managed care organization is providing or administering coverage. A violation
3 of any provision of this section shall constitute an unfair act or practice in the
4 business of insurance in violation of section 4723 of this title.

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

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

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

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

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

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

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

7 (A) a mental health review agent as defined in section ~~4089a~~ 4064 of
8 this title;

9 (B) a health insurer or ~~an affiliate of a health insurer as defined in 18~~
10 ~~V.S.A. § 9402~~ its delegate;

11 (C) a managed care organization ~~or an affiliate of a managed care~~
12 ~~organization,~~ as defined in 18 V.S.A. § 9402, or its delegate; and

13 (D) a any other person or entity that ~~should be licensed as~~ meets the
14 definition of a managed care organization under 18 V.S.A. § 9402 or under
15 rules adopted by the Commissioner.

16 (e) ~~{Repealed.}~~

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

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

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

1 (B) in a mental health facility qualified pursuant to rules adopted by
2 the Secretary of Human Services or in an institution, approved by the Secretary
3 of Human Services, that provides a program for the treatment of a mental
4 condition pursuant to a written plan. ~~A nonprofit hospital or medical service~~
5 ~~corporation may require a mental health facility or licensed or certified mental~~
6 ~~health professional to enter into a contract as a condition of providing benefits.~~

7 (2) For treatment of ~~alcohol or~~ substance abuse disorder, either:

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

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

15 ~~(g), (h) [Repealed.]~~

16 § 4073. DIABETES TREATMENT (formerly § 4089c)

17 (a)(1) A health ~~insurer~~ insurance plan shall provide coverage for the
18 equipment, supplies, and outpatient self-management training and education,
19 including medical nutrition therapy, for the treatment of ~~insulin dependent~~
20 insulin-dependent diabetes, ~~insulin-using~~ insulin-using diabetes, gestational
21 diabetes, and ~~noninsulin-using~~ noninsulin-using diabetes if prescribed by a

1 health care professional ~~legally authorized to prescribe such items under law.~~

2 ~~A health insurer may require that such prescriptions be made, and care be~~

3 ~~given, by a health care professional under contract with the insurer.~~

4 (b)(2) Diabetes outpatient self-management training and education required
5 to be covered by this section shall be provided by a certified, registered, or
6 licensed health care professional with specialized training in the education and
7 management of diabetes.

8 ~~(3) Benefits required to be covered by this section shall be subject to the~~
9 ~~same dollar limits, deductibles, and coinsurance factors within the provisions~~
10 ~~of the health insurance policy.~~

11 ~~(b) For the purposes of this section, “insurer” means any health insurance~~
12 ~~company, nonprofit hospital and medical service corporation, and health~~
13 ~~maintenance organization. The term does not apply to coverage for specified~~
14 ~~disease or other limited benefit coverage.~~

15 § 4074. TREATMENT OF INHERITED METABOLIC DISEASES

16 DISORDERS (formerly § 4089e)

17 (a) ~~For the purposes of~~ As used in this section:

18 (1) “Inherited metabolic ~~disease~~ disorder” means a ~~disease~~ disorder
19 caused by an inherited abnormality of body chemistry for which the State
20 screens newborn infants.

1 (2) ~~“Insurer” means any health insurance company, nonprofit hospital~~
2 ~~and medical service corporation, managed care organization, and health~~
3 ~~maintenance organization. The term does not apply to coverage for specified~~
4 ~~disease or other limited benefit coverage.~~

5 (3) “Low protein modified food product” means a food product that is
6 specifically formulated to have less than one gram of protein per serving and is
7 intended to be used under the direction of a ~~physician~~ health care professional
8 for the dietary treatment of a metabolic ~~disease~~ disorder.

9 (4)(3) “Medical food” means an amino acid modified preparation that is
10 intended to be used under the direction of a ~~physician~~ health care professional
11 for the dietary treatment of an inherited metabolic ~~disease~~ disorder.

12 (b) ~~An insurer~~ A health insurance plan shall provide coverage for medical
13 foods prescribed for medically necessary treatment for an inherited metabolic
14 ~~disease~~ disorder.

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

19 § 4075. CRANIOFACIAL DISORDERS (formerly § 4089g)

20 (a)(1) A health insurance plan shall provide coverage for diagnosis and
21 medically necessary treatment, including surgical and nonsurgical procedures,

1 for a musculoskeletal disorder that affects any bone or joint in the face, neck,
2 or head and is the result of accident, trauma, congenital defect, developmental
3 defect, or pathology. Subject to subsection (b) of this section, this coverage
4 shall be the same as that provided under the health insurance plan for any other
5 musculoskeletal disorder in the body and ~~may be provided~~ shall be covered
6 when the diagnosis or treatment, or both, is prescribed or administered by a
7 physician or a dentist.

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

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

13 ~~(c) As used in this section, “health insurance plan” means any health~~
14 ~~insurance policy or health benefit plan offered by a health insurer as defined in~~
15 ~~18 V.S.A. § 9402. Health insurance plan includes any health benefit plan~~
16 ~~offered or administered by the State, or any subdivision or instrumentality of~~
17 ~~the State.~~

18 § 4076. HOME HEALTH SERVICES (formerly §§ 4095 and 4096)

19 (a) As used in this ~~subchapter~~ section:

1 (1) “Home health agency” means a nonprofit home health agency ~~which~~
2 that has been certified under Title ~~18~~ XVIII of the Social Security Act (42
3 ~~U.S.C.A.~~ U.S.C. § 1395 et seq.).

4 (2) “Home health care” means care and treatment provided by a home
5 health agency and designed and supervised by a ~~physician~~ health care
6 professional, without which care and treatment a person would require
7 ~~institutionalization in~~ admission to a hospital or skilled nursing facility, as
8 those terms are defined by Medicare regulations. The care and treatment shall
9 consist of one or more of the following:

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

11 (B) Physical therapy.

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

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

19 ~~(a)(b)(1) An individual or group health insurance expense policy and an~~
20 ~~individual or group service contract issued by a nonprofit hospital corporation~~

1 ~~which provides hospital or medical coverage~~ A major medical insurance plan
2 shall provide ~~as an option~~ coverage for home health care.

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

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

8 (4) Each visit by a member of a home health care agency, other than a
9 home health aide, shall be considered one home health care visit, and four
10 hours of home health aide service shall be considered one home health care
11 visit. Coverage shall be provided for maternity and childbirth, ~~but such~~
12 ~~coverage may be provided subject to a waiting period of nine months.~~

13 ~~(b)(c) This subchapter does not~~ Nothing in this section shall be deemed to
14 require that home health care coverage be provided to ~~persons~~ individuals
15 eligible for Medicare, ~~nor does it require that the coverage be included in~~
16 ~~indemnity policies or contracts.~~

17 (c) ~~Home health care coverage may be subject to a co-insurance provision~~
18 ~~of not less than 80 percent of reasonable charges and a deductible provision of~~
19 ~~\$50.00 annually; however, if less restrictive benefits are provided by the basic~~
20 ~~hospital or medical coverage, as the case may be, these lesser restrictions shall~~
21 ~~apply to the home health care coverage~~ A health insurance plan shall not

1 impose greater coinsurance, co-payment, deductible, or other cost-sharing
2 requirements for coverage of home health care than apply to the diagnosis and
3 treatment of any other physical or mental condition under the plan.

4 ~~(d) A benefit provided pursuant to this subchapter may be subject to~~
5 ~~utilization review by the nonprofit hospital service corporation. A nonprofit~~
6 ~~hospital service corporation may require a home health agency to enter into a~~
7 ~~contract as a condition of providing benefits.~~

8 § 4077. REPRODUCTIVE HEALTH CARE SERVICES (formerly § 4099c)

9 ~~(a) As used in this section, “health insurance plan” means any individual or~~
10 ~~group health insurance policy, any hospital or medical service corporation or~~
11 ~~health maintenance organization subscriber contract, or any other health~~
12 ~~benefit plan offered, issued, or renewed for any person in this State by a health~~
13 ~~insurer, as defined by 18 V.S.A. § 9402. The term shall not include benefit~~
14 ~~plans providing coverage for a specific disease or other limited benefit~~
15 ~~coverage.~~

16 ~~(b)(1)~~ A health insurance plan shall provide coverage for outpatient
17 contraceptive services including sterilizations, and shall provide coverage for
18 the purchase of all prescription contraceptives and prescription contraceptive
19 devices approved by the ~~federal~~ U.S. Food and Drug Administration (FDA),
20 except that a health insurance plan that does not provide coverage of

1 prescription drugs is not required to provide coverage of prescription
2 contraceptives and prescription contraceptive devices.

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

9 ~~(e)~~(b) A health insurance plan shall provide coverage without any
10 deductible, coinsurance, co-payment, or other cost-sharing requirement for at
11 least one drug, device, or other product within each method of contraception
12 for women identified by the ~~U.S. Food and Drug Administration (FDA)~~ and
13 prescribed by ~~an insured's~~ a covered individual's health care ~~provider~~
14 professional.

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

19 (2)(A) If there is a therapeutic equivalent of a drug, device, or other
20 product for an FDA-approved contraceptive method, a health insurance plan
21 may provide coverage for more than one drug, device, or other product and

1 may impose cost-sharing requirements as long as at least one drug, device, or
2 other product for that method is available without cost sharing.

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

10 ~~(d)~~(c) A health insurance plan shall provide coverage for voluntary
11 sterilization procedures for men and women without any deductible,
12 coinsurance, co-payment, or other cost-sharing requirement, except to the
13 extent that such coverage would disqualify a high-deductible health plan from
14 eligibility for a health savings account pursuant to 26 U.S.C. § 223.

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

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

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

10 ~~(g)~~(f) Benefits provided to an insured under this section shall be the same
11 for the insured's covered spouse and other covered dependents individuals
12 covered under the health insurance plan.

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

16 § 4078. MIDWIFERY COVERAGE; HOME BIRTHS (formerly § 4099d)

17 (a) A health insurance plan ~~or health benefit plan~~ providing maternity
18 benefits shall also provide coverage for services rendered by a midwife
19 licensed pursuant to 26 V.S.A. chapter 85 or an advanced practice registered
20 nurse licensed pursuant to 26 V.S.A. chapter 28 who is certified as a nurse
21 midwife for services within the licensed midwife's or certified nurse midwife's

1 scope of practice and provided in a hospital or other health care facility or at
2 home.

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

7 (c) ~~A health insurance plan may require that the maternity services be~~
8 ~~provided by a licensed midwife or certified nurse midwife under contract with~~
9 ~~the plan.~~

10 (d) ~~As used in this section, “health insurance plan” means any health~~
11 ~~insurance policy or health benefit plan offered by a health insurer, as defined in~~
12 ~~18 V.S.A. § 9402, as well as This section shall apply to Medicaid and any~~
13 ~~other public health care assistance program offered or administered by the~~
14 ~~State or by any subdivision or instrumentality of the State. The term shall not~~
15 ~~include policies or plans providing coverage for specific disease or other~~
16 ~~limited benefit coverage.~~

17 § 4079. ABORTION AND ABORTION-RELATED SERVICES (formerly

18 § 4099e)

19 (a) ~~Definitions.~~ As used in this section:

1 ~~(1) “Abortion”~~ “abortion” means any medical treatment intended to
2 induce the termination of, or to terminate, a clinically diagnosable pregnancy
3 except for the purpose of producing a live birth.

4 ~~(2) “Health insurance plan” means Medicaid and any other public health~~
5 ~~care assistance program, any individual or group health insurance policy, any~~
6 ~~hospital or medical service corporation or health maintenance organization~~
7 ~~subscriber contract, or any other health benefit plan offered, issued, or renewed~~
8 ~~for any person in this State by a health insurer as defined by 18 V.S.A. § 9402.~~
9 ~~For purposes of this section, health insurance plan shall include any health~~
10 ~~benefit plan offered or administered by the State or any subdivision or~~
11 ~~instrumentality of the State. The term shall not include benefit plans providing~~
12 ~~coverage for a specific disease or other limited benefit coverage, except that it~~
13 ~~shall include any accident and sickness health plan.~~

14 ~~(b)(1) Coverage:~~ A health insurance plan shall provide coverage for
15 abortion and abortion-related care.

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

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

1 (1) to the extent such coverage would disqualify a high-deductible
2 health plan from eligibility for a health savings account pursuant to 26 U.S.C.
3 § 223; and

4 (2) for coverage provided by Medicaid.

5 § 4080. ANESTHESIA FOR CERTAIN DENTAL PROCEDURES (formerly
6 § 4100i)

7 ~~(a)~~ As used in this section:

8 (1) “Ambulatory surgical center” shall have the same meaning as in
9 18 V.S.A. ~~§ 9432~~ § 2141.

10 (2) “Anesthesiologist” means a ~~person~~ physician who is licensed ~~to~~
11 ~~practice medicine or osteopathy~~ under 26 V.S.A. chapter 23 or 33 and who
12 either:

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

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

18 (3) “Certified registered nurse anesthetist” means an advanced practice
19 registered nurse licensed by the Vermont Board of Nursing to practice as a
20 certified registered nurse anesthetist.

1 (4) ~~“Health insurance plan” means any health insurance policy or health~~
2 ~~benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, but~~
3 ~~does not include policies or plans providing coverage for a specified disease or~~
4 ~~other limited benefit coverage.~~

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

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

15 (1) a child seven years of age or younger who is determined by a dentist
16 licensed pursuant to 26 V.S.A. chapter 13 to be unable to receive needed dental
17 treatment in an outpatient setting, where the provider treating the ~~patient~~
18 covered individual certifies that due to the ~~patient’s~~ covered individual’s age
19 and the ~~patient’s~~ covered individual’s condition or problem, hospitalization or
20 general anesthesia in a hospital or ambulatory surgical center is required in

1 order to perform significantly complex dental procedures safely and
2 effectively;

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

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

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

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

- 1 (1) a fully accredited specialist in pediatric dentistry;
- 2 (2) a fully accredited specialist in oral and maxillofacial surgery; and
- 3 (3) a dentist to whom hospital privileges have been granted.

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

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

14 ~~(f) As used in this section:~~

15 ~~(1) "Ambulatory surgical center" shall have the same meaning as in 18~~
16 ~~V.S.A. § 9432.~~

17 ~~(2) "Anesthesiologist" means a person who is licensed to practice~~
18 ~~medicine or osteopathy under 26 V.S.A. chapter 23 or 33 and who either:~~

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

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

3 ~~(3) “Certified registered nurse anesthetist” means an advanced practice~~
4 ~~registered nurse licensed by the Vermont Board of Nursing to practice as a~~
5 ~~certified registered nurse anesthetist.~~

6 ~~(4) “Health insurance plan” means any health insurance policy or health~~
7 ~~benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, but~~
8 ~~does not include policies or plans providing coverage for a specified disease or~~
9 ~~other limited benefit coverage.~~

10 ~~(5) “Licensed mental health professional” means a licensed physician,~~
11 ~~psychologist, social worker, mental health counselor, or nurse with~~
12 ~~professional training, experience, and demonstrated competence in the~~
13 ~~treatment of a mental condition or psychiatric disability.~~

14 § 4081. TOBACCO CESSATION PROGRAMS (formerly § 4100j)

15 (a) As used in this section, “tobacco cessation medication” means all
16 therapies approved by the federal U.S. Food and Drug Administration for use
17 in tobacco cessation.

18 (b) A health insurance plan shall provide coverage of at least one three-
19 month supply per year of tobacco cessation medication, including over-the-
20 counter medication, if prescribed by a licensed health care ~~practitioner~~
21 professional for an individual ~~insured~~ covered under the plan. A health

1 insurance plan may require the individual to pay the plan’s applicable
2 prescription drug co-payment for the tobacco cessation medication.

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

6 ~~(b) As used in this subchapter:~~

7 ~~(1) “Health insurance plan” means any health insurance policy or health~~
8 ~~benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well~~
9 ~~as Medicaid and any other public health care assistance program offered or~~
10 ~~administered by the State or by any subdivision or instrumentality of the State.~~
11 ~~The term does not include policies or plans providing coverage for specified~~
12 ~~disease or other limited benefit coverage.~~

13 ~~(2) “Tobacco cessation medication” means all therapies approved by the~~
14 ~~federal Food and Drug Administration for use in tobacco cessation.~~

15 § 4082. EARLY CHILDHOOD DEVELOPMENT DISORDERS (formerly

16 § 4088i)

17 ~~(a)~~ As used in this section:

18 (1) “Applied behavior analysis” means the design, implementation, and
19 evaluation of environmental modifications using behavioral stimuli and
20 consequences to produce socially significant improvement in human behavior.

1 The term includes the use of direct observation, measurement, and functional
2 analysis of the relationship between environment and behavior.

3 (2) “Autism spectrum disorders” means one or more pervasive
4 developmental disorders as defined in the most recent edition of the Diagnostic
5 and Statistical Manual of Mental Disorders (DSM), including autistic disorder,
6 pervasive developmental disorder not otherwise specified, and Asperger’s
7 disorder.

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

10 (A) necessary to develop skills and abilities for the maximum
11 reduction of physical or mental disability and for restoration of an individual to
12 ~~his or her~~ the individual’s best functional level, or to ensure that an individual
13 under ~~the age of~~ 21 years of age achieves proper growth and development; and

14 (B) provided or supervised by a nationally board-certified behavior
15 analyst or by a licensed ~~provider~~ health care professional, ~~so long as provided~~
16 the services performed are within the ~~provider’s~~ health care professional’s
17 scope of practice and certifications.

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

1 (5) “Early childhood developmental disorder” means a childhood mental
2 or physical impairment or combination of mental and physical impairments
3 that results in functional limitations in major life activities, accompanied by a
4 diagnosis defined by the ~~Diagnostic and Statistical Manual of Mental~~
5 ~~Disorders~~ (DSM) or the International Classification of ~~Disease~~ Diseases (ICD),
6 as periodically revised. The term includes autism spectrum disorders, but does
7 not include a learning disability.

8 (6) “Evidence-based” ~~means the same~~ has the same meaning as in 18
9 V.S.A. § 4621.

10 (7) ~~“Health insurance plan” means Medicaid and any other public health~~
11 ~~care assistance program, any individual or group health insurance policy, any~~
12 ~~hospital or medical service corporation or health maintenance organization~~
13 ~~subscriber contract, or any other health benefit plan offered, issued, or renewed~~
14 ~~for any person in this State by a health insurer, as defined in 18 V.S.A. § 9402.~~
15 ~~The term does not include benefit plans providing coverage for specific~~
16 ~~diseases or other limited benefit coverage.~~

17 (8) “Medically necessary” describes health care services that are
18 appropriate in terms of type, amount, frequency, level, setting, and duration to
19 the individual’s diagnosis or condition; are informed by generally accepted
20 medical or scientific evidence; and are consistent with generally accepted
21 practice parameters. Such services shall be informed by the unique needs of

1 each individual and each presenting situation, and shall include a determination
2 that a service is needed to achieve proper growth and development or to
3 prevent the onset or worsening of a health condition.

4 ~~(9)~~(8) “Natural environment” means a home or child care setting.

5 ~~(10)~~(9) “Pharmacy care” means medications prescribed by a licensed
6 ~~physician~~ health care professional and any health-related services deemed
7 medically necessary to determine the need for or effectiveness of a medication.

8 ~~(11)~~(10) “Psychiatric care” means direct or consultative services
9 provided by a licensed physician certified in psychiatry by the American Board
10 of Medical Specialties.

11 ~~(12)~~(11) “Psychological care” means direct or consultative services
12 provided by a psychologist licensed pursuant to 26 V.S.A. chapter 55.

13 ~~(13)~~(12) “Therapeutic care” means services provided by licensed or
14 certified speech language pathologists, occupational therapists, or physical
15 therapists.

16 ~~(14)~~(13) “Treatment for early developmental disorders” means
17 evidence-based care and related equipment prescribed or ordered for an
18 individual by a licensed health care ~~provider~~ professional or a licensed
19 psychologist who determines the care to be medically necessary, including:

20 (A) behavioral health treatment;

21 (B) pharmacy care;

- 1 (C) psychiatric care;
- 2 (D) psychological care; and
- 3 (E) therapeutic care.

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

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

15 (3) ~~Any~~ A major medical insurance plan is not required to provide any
16 benefits required by this section that exceed the essential health benefits
17 specified under Section 1302(b) of the Patient Protection and Affordable Care
18 Act, Public Law 111-148, as amended, ~~shall not be required in a health~~
19 ~~insurance plan offered in the individual, small group, and large group markets~~
20 ~~on and after January 1, 2014.~~

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

4 ~~(e)~~(d) A health insurance plan shall not impose greater coinsurance, co-
5 payment, deductible, or other cost-sharing requirements for coverage of the
6 diagnosis or treatment of early childhood developmental disorders than apply
7 to the diagnosis and treatment of any other physical or mental condition under
8 the plan.

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

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

1 ~~(e)~~(f) Except for inpatient services, if an individual is receiving treatment
2 for an early developmental delay, the health insurance plan may require
3 treatment plan reviews based on the needs of the covered individual
4 beneficiary, consistent with reviews for other diagnostic areas and with rules
5 established by the Department of Financial Regulation. A health insurance
6 plan may review the treatment plan for children under ~~the age of~~ eight years of
7 age no more frequently than once every six months.

8 (g) Nothing in this section shall be construed to affect any obligation to
9 provide services to an individual under an individualized family service plan,
10 individualized education program, or individualized service plan. A health
11 insurance plan shall not reimburse services provided under 16 V.S.A. § 2959a.

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

16 § 4083. SERVICES FOR VICTIMS OF SEXUAL ASSAULT (formerly
17 § 4089)

18 ~~(a)~~(b) As used in this section, “sexual assault examination” means either or
19 both of the following:

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

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

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

12 ~~(b) As used in this section:~~

13 ~~(1) “Health insurer” shall have the same meaning as in 18 V.S.A. § 9402.~~

14 ~~(2) “Sexual assault examination” means either or both of the following:~~

15 ~~(A) a physical examination of the patient, documentation of biological~~
16 ~~and physical findings, and collection of evidence; and~~

17 ~~(B) treatment of the patient’s injuries; providing care for sexually~~
18 ~~transmitted infections; assessing pregnancy risk; discussing treatment options~~
19 ~~including reproductive health services, screening for the human~~
20 ~~immunodeficiency virus, and prophylactic treatment when appropriate; and~~
21 ~~providing instructions and referrals for follow up care.~~

1 § 4084. PHYSICAL THERAPY CO-PAYMENTS FOR CERTAIN PLANS

2 (formerly § 4088k)

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

10 Subchapter 10. Prescription Drug Coverage

11 § 4091. DEFINITIONS (NEW but combines from §§ 4089i and 4089j)

12 (a) Definitions. As used in this subchapter:

13 (1) “Direct solicitation” means direct contact, including telephone,
14 computer, e-mail, instant messaging, or in-person contact, by a pharmacy
15 provider or its agent to a ~~beneficiary of~~ an individual covered under a health
16 insurance plan offered by a health insurer without the ~~beneficiary’s~~ covered
17 individual’s consent for the purpose of marketing the pharmacy provider’s
18 services.

19 (2) “Health care professional” means an individual licensed to practice
20 medicine under 26 V.S.A. chapter 23 or 33, an individual licensed as a

1 physician assistant under 26 V.S.A. chapter 31, or an individual licensed as an
2 advanced practice registered nurse under 26 V.S.A. chapter 28.

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

6 (4) “Interchangeable biological products” ~~shall have~~ has the same
7 meaning as in 18 V.S.A. § 4601.

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

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

17 (A) mail service pharmacy;

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

20 (C) clinical formulary development and management services;

21 (D) rebate contracting and administration;

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

3 (F) disease management programs.

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

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

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

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

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

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

18 (9) “Prescription insulin medication” means a prescription ~~medication~~
19 drug that contains insulin and is used to treat diabetes.

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

4 § 4092. PRESCRIPTION DRUG COVERAGE

5 (formerly § 4089i w/2024 amendments and § 4088e)

6 (a) ~~A health insurance or other health benefit plan offered by a health~~
7 ~~insurer shall provide coverage for prescription drugs purchased in Canada, and~~
8 ~~used in Canada or reimported legally or purchased through the I-SaveRx~~
9 ~~program on the same benefit terms and conditions as prescription drugs~~
10 ~~purchased in this country. For drugs purchased by mail or through the Internet,~~
11 ~~the plan may require accreditation by the Internet and Mailorder Pharmacy~~
12 ~~Accreditation Commission (IMPAC/tm) or similar organization.~~

13 (b) ~~A health insurance or other health benefit plan offered by a health~~
14 ~~insurer or pharmacy benefit manager shall not include an annual dollar limit on~~
15 ~~prescription drug benefits.~~

16 (e)(b) ~~A health insurance or other health benefit plan offered by a health~~
17 ~~insurer or pharmacy benefit manager shall limit a beneficiary's covered~~
18 ~~individual's out-of-pocket expenditures for all prescription drugs, including~~
19 ~~specialty drugs, to no not more for self-only and family coverage per year than~~
20 ~~the minimum dollar amounts in effect under Section 223(c)(2)(A)(i) of the~~
21 ~~Internal Revenue Code of 1986 for self-only and family coverage, respectively.~~

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

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

14 ~~(e)~~(d)(1) A health insurance ~~or other health benefit plan offered by a health~~
15 ~~insurer or by a pharmacy benefit manager on behalf of a health insurer that~~
16 ~~provides coverage for prescription drugs and~~ uses step-therapy protocols shall:

17 (A) not require failure, including discontinuation due to lack of
18 efficacy or effectiveness, diminished effect, or an adverse event, on the same
19 ~~medication~~ drug on more than one occasion for ~~insureds~~ covered individuals
20 who are continuously enrolled in a plan offered by the health insurer or its
21 pharmacy benefit manager; and

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

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

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

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

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

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

4 (I) pose a barrier to adherence;

5 (II) likely worsen a comorbid condition; or

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

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

11 (3) Notwithstanding any provision of subdivision (1) of this subsection
12 to the contrary, a health insurance ~~or other health benefit plan offered by an~~
13 ~~insurer or by a pharmacy benefit manager on behalf of a health insurer that~~
14 ~~provides coverage for prescription drugs~~ shall not utilize a step-therapy, “fail
15 first,” or other protocol that requires documented trials of a ~~medication~~
16 prescription drug, including a trial documented through a “MedWatch” (FDA
17 Form 3500), before approving a prescription for the treatment of substance use
18 disorder.

19 ~~(f)(e)(1)~~ A health insurance ~~or other health benefit plan offered by a health~~
20 ~~insurer or by a pharmacy benefit manager on behalf of a health insurer that~~
21 ~~provides coverage for prescription drugs~~ shall not require, as a condition of

1 coverage, use of drugs not indicated by the ~~federal~~ U.S. Food and Drug
2 Administration for the condition diagnosed and being treated under the
3 supervision of a health care professional.

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

6 ~~(g)(f)~~ A health insurance ~~or other health benefit plan offered by a health~~
7 ~~insurer or by a pharmacy benefit manager on behalf of a health insurer that~~
8 ~~provides coverage for prescription drugs~~ shall apply the same cost-sharing
9 requirements to interchangeable biological products as apply to generic drugs
10 under the plan.

11 ~~(h)(g)~~(1) A health insurance ~~or other health benefit plan offered by a health~~
12 ~~insurer or pharmacy benefit manager~~ shall limit a beneficiary's covered
13 individual's total out-of-pocket responsibility for prescription insulin
14 ~~medications~~ drugs to not more than \$100.00 per 30-day supply, regardless of
15 the amount, type, or number of insulin ~~medications~~ drugs prescribed for the
16 beneficiary covered individual.

17 (2) The \$100.00 monthly limit on out-of-pocket spending for
18 prescription insulin ~~medications~~ drugs set forth in subdivision (1) of this
19 subsection shall apply regardless of whether the beneficiary covered individual
20 has satisfied any applicable deductible requirement under the health insurance
21 ~~or health benefit~~ plan.

1 ~~(i)~~(h) A health insurance ~~or other health benefit plan offered by a health~~
2 ~~insurer or by a pharmacy benefit manager on behalf of a health insurer~~ shall
3 cover, without requiring prior authorization, at least one readily available
4 asthma controller ~~medication~~ drug from each class of ~~medication~~ drug and
5 mode of administration. As used in this subsection, “readily available” means
6 that the medication is not listed on a national drug shortage list, including lists
7 maintained by the U.S. Food and Drug Administration and by the American
8 Society of Health-System Pharmacists.

9 ~~(j) As used in this section:~~

10 ~~(1) “Health care professional” means an individual licensed to practice~~
11 ~~medicine under 26 V.S.A. chapter 23 or 33, an individual licensed as a~~
12 ~~physician assistant under 26 V.S.A. chapter 31, or an individual licensed as an~~
13 ~~advanced practice registered nurse under 26 V.S.A. chapter 28.~~

14 ~~(2) “Health insurer” shall have the same meaning as in 18 V.S.A. § 9402.~~

15 ~~(3) “Out-of-pocket expenditure” means a co-payment, coinsurance,~~
16 ~~deductible, or other cost sharing mechanism.~~

17 ~~(4) “Pharmacy benefit manager” shall have the same meaning as in~~
18 ~~section 4089j of this title.~~

19 ~~(5) “Step therapy” means protocols that establish the specific sequence in~~
20 ~~which prescription drugs for a specific medical condition are to be prescribed.~~

1 ~~(6) “Interchangeable biological products” shall have the same meaning~~
2 ~~as in 18 V.S.A. § 4601.~~

3 ~~(7) “Prescription insulin medication” means a prescription medication~~
4 ~~that contains insulin and is used to treat diabetes.~~

5 ~~(k)(i)~~ On a periodic basis, no but not less than once per calendar year, a
6 ~~health insurer as defined in 18 V.S.A. § 9471(2)(A), (C), and (D)~~ each health
7 insurer shall notify ~~beneficiaries of all individuals covered under its health~~
8 insurance plans of any changes in pharmaceutical coverage and provide access
9 to the preferred drug list maintained by the health insurer or its pharmacy
10 benefit manager.

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

13 ~~(a)(k)~~ A health insurance ~~or other health benefit plan offered by a health~~
14 ~~insurer~~ shall provide coverage for prescription drugs purchased in Canada, and
15 used in Canada or reimported legally ~~or purchased through the I-SaveRx~~
16 ~~program~~ on the same benefit terms and conditions as prescription drugs
17 purchased in this country. For drugs purchased by mail or through the Internet
18 internet, the plan may require accreditation by the Internet and Mailorder
19 Pharmacy Accreditation Commission (IMPAC/tm) or similar organization.

20 § 4093. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS (formerly
21 § 4089j)

1 (a) ~~As used in this section:~~

2 (1) ~~“Health insurer” shall have the same meaning as in 18 V.S.A. § 9402~~
3 ~~and shall also include Medicaid and any other public health care assistance~~
4 ~~program.~~

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

11 (A) ~~mail service pharmacy;~~

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

14 (C) ~~clinical formulary development and management services;~~

15 (D) ~~rebate contracting and administration;~~

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

18 (F) ~~disease management programs.~~

19 (3) ~~“Health care provider” means a person, partnership, or corporation,~~
20 ~~other than a facility or institution, that is licensed, certified, or otherwise~~

1 authorized by law to provide professional health care services in this State to
2 an individual during that individual's medical care, treatment, or confinement.

3 (4) ~~“Pharmacy benefit manager affiliate” means a pharmacy or~~
4 ~~pharmacist that, directly or indirectly, through one or more intermediaries, is~~
5 ~~owned or controlled by, or is under common ownership or control with, a~~
6 ~~pharmacy benefit manager.~~

7 (5) ~~“Drug” or “prescription drug” has the same meaning as “prescription~~
8 ~~drug” in 26 V.S.A. § 2022 and includes:~~

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

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

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

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

17 (b) A health insurer or pharmacy benefit manager doing business in
18 Vermont shall permit a retail pharmacist licensed under 26 V.S.A. chapter 36
19 to fill prescriptions for all prescription drugs in the same manner and at the
20 same level of reimbursement as they are filled by any other pharmacist or
21 pharmacy, including a mail-order pharmacy or a pharmacy benefit manager

1 affiliate, with respect to the quantity of drugs or days' supply of drugs
2 dispensed under each prescription.

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

8 ~~(d)~~(c)(1) A health insurer or pharmacy benefit manager shall permit a
9 participating network pharmacy to perform all pharmacy services within the
10 lawful scope of the profession of pharmacy as set forth in 26 V.S.A. chapter
11 36.

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

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

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

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

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

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

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

19 (I) the out-of-pocket limits for prescription drug costs under
20 section ~~4089~~ 4092 of this title;

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

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

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

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

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

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

19 (3) A health insurer or pharmacy benefit manager shall not, by contract,
20 written policy, or written procedure, require that a pharmacy designated by the
21 health insurer or pharmacy benefit manager dispense a medication directly to a

1 ~~patient~~ covered individual with the expectation or intention that the ~~patient~~
2 covered individual will transport the medication to a health care setting for
3 administration by a health care professional.

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

9 (5) A health insurer or pharmacy benefit manager shall adhere to the
10 definitions of prescription drugs and the requirements and guidance regarding
11 the pharmacy profession established by State and federal law and the Vermont
12 Board of Pharmacy and shall not establish classifications of or distinctions
13 between prescription drugs, impose penalties on prescription drug claims,
14 attempt to dictate the behavior of pharmacies or pharmacists, or place
15 restrictions on pharmacies or pharmacists that are more restrictive than or
16 inconsistent with State or federal law or with rules adopted or guidance
17 provided by the Board of Pharmacy.

18 (6) A pharmacy benefit manager or licensed pharmacy shall not make a
19 direct solicitation to ~~the beneficiary of~~ an individual covered by a health
20 insurance plan offered by a health insurer unless one or more of the following
21 applies:

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

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

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

13 ~~(7) The provisions of this subsection shall not apply to Medicaid.~~

14 ~~(e)~~(d) A health insurer or pharmacy benefit manager shall not alter a
15 ~~patient's~~ covered individual's prescription drug order or the pharmacy chosen
16 by the ~~patient~~ covered individual without the ~~patient's~~ covered individual's
17 consent; provided, however, that nothing in this subsection shall be construed
18 to affect the duty of a pharmacist to substitute a lower-cost drug or biological
19 product in accordance with the provisions of 18 V.S.A. § 4605.

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

4 Subchapter 11. Prevention and Treatment of Cancer

5 § 4095a. COLORECTAL CANCER SCREENING (formerly § 4100g)

6 (a) ~~For purposes of this section:~~

7 ~~(1) “Colonoscopy”~~ As used in this section, “colonoscopy” means a
8 procedure that enables a ~~clinician~~ health care professional to examine visually
9 the inside of a patient’s entire colon and includes the concurrent removal of
10 polyps or biopsy, or both.

11 ~~(2) “Insurer” means insurance companies that provide health insurance~~
12 ~~as defined in subdivision 3301(a)(2) of this title, nonprofit hospital and~~
13 ~~medical services corporations, and health maintenance organizations. The~~
14 ~~term does not apply to coverage for specified disease or other limited benefit~~
15 ~~coverage.~~

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

18 (1) ~~for an insured~~ a covered individual who is not at high risk for
19 colorectal cancer, colorectal cancer screening examinations and laboratory
20 tests in accordance with the most recently published recommendations

1 established by the U.S. Preventive Services Task Force for average-risk
2 individuals; and

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

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

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

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

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

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

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

21 (1) removal of tissue or other matter;

- 1 (2) laboratory services;
- 2 (3) ~~clinician~~ health care professional services;
- 3 (4) facility use; and
- 4 (5) anesthesia.

5 § 4095b. MAMMOGRAPHY AND OTHER BREAST IMAGING

6 SERVICES (formerly § 4100a, w/2024 amendments effective
7 1/1/2026)

8 (a)(1) ~~Insurers~~ A health insurance plan shall provide coverage for screening
9 mammography and for other medically necessary breast imaging services upon
10 recommendation of a health care ~~provider~~ professional as needed to detect the
11 presence of breast cancer and other abnormalities of the breast or breast tissue.
12 In addition, ~~insurers~~ a health insurance plan shall provide coverage for
13 screening by ultrasound or another appropriate imaging service for a ~~patient~~
14 covered individual for whom the results of a screening mammogram were
15 inconclusive or who has dense breast tissue, or both.

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

1 (b) ~~{Repealed.}~~

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

4 (d)(c) As used in this ~~subchapter~~ section:

5 (1) ~~“Insurer” means any insurance company that provides health~~
6 ~~insurance as defined in subdivision 3301(a)(2) of this title, nonprofit hospital~~
7 ~~and medical service corporations, and health maintenance organizations. The~~
8 ~~term does not apply to coverage for specified diseases or other limited benefit~~
9 ~~coverage.~~

10 (2) ~~“Mammography”~~ means the x-ray examination of the breast using
11 equipment dedicated specifically for mammography, including the x-ray tube,
12 filter, compression device, and digital detector. The term includes breast
13 tomosynthesis.

14 (3)(2) ~~“Other breast imaging services”~~ means diagnostic mammography,
15 ultrasound, and magnetic resonance imaging services that enable health care
16 ~~providers~~ professionals to detect the presence or absence of breast cancer and
17 other abnormalities affecting the breast or breast tissue.

18 (4)(3) ~~“Screening”~~ includes the mammography or ultrasound test
19 procedure and a qualified ~~physician’s~~ health care professional’s interpretation
20 of the results of the procedure, including additional views and interpretation as
21 needed.

1 § 4095c. PROSTATE CANCER SCREENINGS (formerly § 4100f)

2 ~~(a) Health insurers~~ A health insurance plan shall provide coverage for
3 prostate cancer screenings consistent with the recommendations ~~by~~ of the
4 Centers for Disease Control and Prevention or upon recommendation of ~~a~~ the
5 covered individual's health care ~~provider~~ professional. Benefits provided shall
6 be at least as favorable as coverage for other cancer screening procedures and
7 subject to the same dollar limits, deductibles, and coinsurance factors within
8 the provisions of the policy.

9 ~~(b) For purposes of this section, "health insurer" is defined by 18 V.S.A. §~~
10 ~~9402. The term does not apply to coverage for specified disease or other~~
11 ~~limited benefit coverage.~~

12 § 4095d. CHEMOTHERAPY TREATMENT AND ORAL ANTICANCER
13 MEDICATIONS (formerly §§ 4088c and 4100h)

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

17 ~~(a)(b)~~ A health insurer that provides coverage for cancer chemotherapy
18 ~~treatment~~ insurance plan shall provide coverage for prescribed, orally
19 administered anticancer medications used to kill or slow the growth of
20 cancerous cells that is ~~no~~ not less favorable on a financial basis than

1 intravenously administered or injected anticancer medications covered under
2 the ~~insured's~~ covered individual's plan.

3 § 4095e. CLINICAL TRIALS FOR CANCER PATIENTS (formerly § 4088b)

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

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

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

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

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

3 (B) the ~~patient~~ covered individual already has completed a clinical
4 trial ~~under subdivision (A) of this subdivision (3)~~ at one of the Vermont or
5 New Hampshire cancer care providers described in subdivision (2) of this
6 subsection (a) and the patient's covered individual's cancer care provider
7 determines that a subsequent clinical trial related to the original diagnosis is
8 available outside the health benefit plan's network and ~~determines that~~
9 participation in that clinical trial would be in the best ~~interest~~ interests of the
10 ~~patient~~ covered individual, even if a comparable clinical trial is available at
11 that time ~~under subdivision (2) of this subsection (a)~~ at one or both of the
12 Vermont or New Hampshire cancer care providers described in subdivision (2)
13 of this subsection (a); or

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

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

7 (b) ~~As used in this section, “health benefit plan” means any health~~
8 ~~insurance policy or health benefit plan offered by a health insurer as defined in~~
9 ~~18 V.S.A. § 9402.~~

10 (e) ~~The Vermont Agency of Human Services through its Vermont Medicaid~~
11 ~~program shall participate in the provisions of this section in the same manner~~
12 ~~as insurers as defined in 18 V.S.A. § 9402.~~

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

16 (d) ~~Notwithstanding 3 V.S.A. chapter 25, the Commissioner shall amend~~
17 ~~rules adopted under this section for the sole purpose of eliminating any sunset~~
18 ~~provision in the rule by filing a new adopted rule with the Secretary of State~~
19 ~~and the Legislative Committee on Administrative Rules. The new adopted rule~~
20 ~~shall be effective when filed.~~

1 § 4095f. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR CANCER

2 (formerly § 4100e)

3 ~~(b)(a)~~ As used in this section, ~~the following terms have the following~~
4 meanings:

5 ~~(1) “Health insurance plan” means a health benefit plan offered,~~
6 ~~administered, or issued by a health insurer doing business in Vermont.~~

7 ~~(2) “Health insurer” is defined by 18 V.S.A. § 9402. As used in this~~
8 ~~subchapter, the term includes the State of Vermont and any agent or~~
9 ~~instrumentality of the State that offers, administers, or provides financial~~
10 ~~support to State government, including Medicaid or any other public health~~
11 ~~care assistance program.~~

12 (1) “Medical or scientific evidence” means one or more of the following
13 sources:

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

18 (B) peer-reviewed literature, biomedical compendia, and other
19 medical literature that meet the criteria of the National Institutes of Health’s
20 National Library of Medicine for indexing in Index Medicus, Excerpta

1 Medicus (EMBASE), Medline, and MEDLARS database Health Services
2 Technology Assessment Research (HSTAR);

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

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

10 (E) findings, studies, or research conducted by or under the auspices
11 of federal government agencies and nationally recognized federal research
12 institutes, including the Agency for Health Care Policy and Research, National
13 Institutes of Health, National Cancer Institute, National Academy of Sciences,
14 Centers for Medicare and Medicaid Services, and any national board
15 recognized by the National Institutes of Health for the purpose of evaluating
16 the medical value of health services; and

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

19 ~~(3)~~(2) “Medically accepted indication” includes any use of a drug that
20 has been approved by the ~~federal~~ U.S. Food and Drug Administration and
21 includes another use of the drug if that use is prescribed by the ~~insured’s~~

1 ~~treating oncologist~~ covered individual's health care professional and supported
2 by medical or scientific evidence. ~~As used in this subchapter, "medical or~~
3 ~~scientific evidence" means~~

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

7 ~~(a)(b)~~ A health insurance plan ~~that provides coverage for prescription drugs~~
8 shall provide coverage for off-label use in cancer treatment in accordance with
9 the following:

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

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

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

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

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

6 (c) A determination by a health insurer that an off-label use of a
7 prescription drug under this section is not a medically accepted indication
8 supported by medical or scientific evidence is eligible for review under section
9 ~~4089f~~ 4063 of this title.

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

13 Subchapter 12. Service Delivery and Treatment Modalities

14 § 4098a. COVERAGE OF HEALTH CARE SERVICES DELIVERED

15 THROUGH TELEMEDICINE AND BY STORE-AND-FORWARD

16 MEANS (formerly § 4100k)

17 ~~(i)~~(a) As used in this ~~subchapter~~ section:

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

20 (2) “Health insurance plan” ~~means any health insurance policy or health~~
21 ~~benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402;~~ has the

1 same meaning as in section 4011 of this title and also includes a stand-alone
2 dental plan or policy or other dental insurance plan offered by a dental insurer;
3 ~~and Medicaid and any other public health care assistance program offered or~~
4 ~~administered by the State or by any subdivision or instrumentality of the State.~~
5 ~~The term does not include policies or plans providing coverage for a specified~~
6 ~~disease or other limited benefit coverage.~~

7 (3) “Health care facility” ~~shall have~~ has the same meaning as in 18
8 V.S.A. § 9402.

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

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

20 (6) “Store and forward” means an asynchronous transmission of medical
21 information, such as one or more video clips, audio clips, still images, x-rays,

1 magnetic resonance imaging scans, electrocardiograms,
2 electroencephalograms, or laboratory results, sent over a secure connection that
3 complies with the requirements of the Health Insurance Portability and
4 Accountability Act of 1996, Pub. L. No. 104-191 to be reviewed at a later date
5 by a health care provider at a distant site who is trained in the relevant
6 specialty. In store and forward, the health care provider at the distant site
7 reviews the medical information without the patient present in real time and
8 communicates a care plan or treatment recommendation back to the patient or
9 referring provider, or both.

10 (7) “Telemedicine” means the delivery of health care services, including
11 dental services, such as diagnosis, consultation, or treatment, through the use
12 of live interactive audio and video over a secure connection that complies with
13 the requirements of the Health Insurance Portability and Accountability Act of
14 1996, Pub. L. No. 104-191.

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

20 (2)(A) A health insurance plan shall provide the same reimbursement
21 rate for services billed using equivalent procedure codes and modifiers, subject

1 to the terms of the health insurance plan and provider contract, regardless of
2 whether the service was provided through an in-person visit with the health
3 care provider or through telemedicine.

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

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

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

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

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

20 (d) Nothing in this section shall be construed to prohibit a health insurance
21 plan from providing coverage for only those services that are medically

1 necessary and are clinically appropriate for delivery through telemedicine,
2 subject to the terms and conditions of the covered ~~person's~~ individual's policy.

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

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

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

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

20 (h) In order to facilitate the use of telemedicine in treating substance use
21 disorder, when the originating site is a health care facility, health insurers and

1 the Department of Vermont Health Access shall ensure that the health care
2 provider at the distant site and the health care facility at the originating site are
3 both reimbursed for the services rendered, unless the health care providers at
4 both the distant and originating sites are employed by the same entity.

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

8 § 4098b. COVERAGE OF HEALTH CARE SERVICES DELIVERED BY
9 AUDIO-ONLY TELEPHONE (formerly § 4100l)

10 (a) As used in this section:

11 (1) “~~Health~~ health care provider” means a person, partnership, or
12 corporation, other than a facility or institution, that is licensed, certified, or
13 otherwise authorized by law to provide professional health care services in this
14 State to an individual during that individual’s medical care, treatment, or
15 confinement.

16 (2) “~~Health insurance plan~~” means ~~any health insurance policy or health~~
17 ~~benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402;~~
18 ~~Medicaid, to the extent permitted by the Centers for Medicare and Medicaid~~
19 ~~Services; and any other public health care assistance program offered or~~
20 ~~administered by the State or by any subdivision or instrumentality of the State.~~

1 ~~The term does not include policies or plans providing coverage for a specified~~
2 ~~disease or other limited benefit coverage.~~

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

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

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

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

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

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

8 § 4098c. COVERED SERVICES PROVIDED BY NATUROPATHIC

9 PHYSICIANS (formerly § 4088d)

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

15 (b) Health care services provided by naturopathic physicians may be
16 subject to reasonable deductibles, co-payment and coinsurance amounts, and
17 fee or benefit limits consistent with those applicable to other primary care
18 physicians under the plan, as well as practice parameters, cost-effectiveness
19 and clinical efficacy standards, and utilization review consistent with any
20 applicable rules published by the Department of Financial Regulation. Any
21 amounts, limits, standards, and review shall not function to direct treatment in

1 a manner unfairly discriminative against naturopathic care, and collectively
2 shall be not more restrictive than those applicable under the same ~~policy plan~~
3 to care or services provided by other primary care physicians, but may allow
4 for the management of the benefit consistent with variations in practice
5 patterns and treatment modalities among different types of health care
6 ~~providers~~ professionals.

7 (c) A health insurance plan may require that the naturopathic physician's
8 services be provided by a licensed naturopathic physician under contract with
9 the insurer or shall be covered in a manner consistent with out-of-network
10 provider reimbursement practices for primary care physicians; however, this
11 shall not relieve a health insurance plan from compliance with the applicable
12 network adequacy requirements adopted by the Commissioner by rule.

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

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

20 ~~(b) As used in this section, "health insurance plan" means Medicaid and~~
21 ~~any other public health care assistance program, any individual or group health~~

1 ~~insurance policy, any hospital or medical service corporation or health~~
2 ~~maintenance organization subscriber contract, or any other health benefit plan~~
3 ~~offered, issued, or renewed for any person in this State by a health insurer, as~~
4 ~~defined by 18 V.S.A. § 9402. The term shall not include benefit plans~~
5 ~~providing coverage for a specific disease or other limited benefit coverage.~~

6 § 4098d. COVERED SERVICES PROVIDED BY ATHLETIC TRAINERS

7 (formerly § 4088g)

8 (a) To the extent a health insurance plan provides coverage for a particular
9 type of health care service or for any particular medical condition that is within
10 the scope of practice of athletic trainers, a licensed athletic trainer who acts
11 within the scope of practice authorized by ~~law~~ 26 V.S.A. chapter 83 shall not
12 be denied reimbursement by the health ~~insurer~~ insurance plan for those covered
13 services if the health ~~insurer~~ insurance plan would reimburse another health
14 care ~~provider professional~~ for those services. ~~A health insurer may require that~~
15 ~~the athletic trainer services be provided by a licensed athletic trainer under~~
16 ~~contract with the insurer.~~

17 (b) ~~Services~~ Health care services provided by athletic trainers may be
18 subject to reasonable deductibles, co-payment and co-insurance amounts, fee
19 or benefit limits, practice parameters, and utilization review consistent with
20 applicable rules adopted by the Department of Financial Regulation, provided
21 that the amounts, limits, and review shall not function to direct treatment in a

1 manner unfairly discriminative against athletic trainer care, and collectively
2 shall be ~~no~~ not more restrictive than those applicable under the same policy for
3 care or services provided by other health care ~~providers~~ professionals but
4 allowing for the management of the benefit consistent with variations in
5 practice patterns and treatment modalities among different types of health care
6 ~~providers~~ professionals.

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

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

12 ~~(b) As used in this section, “health insurance plan” means an individual or~~
13 ~~group health insurance policy, a hospital or medical service corporation or~~
14 ~~health maintenance organization subscriber contract, or another health benefit~~
15 ~~plan offered, issued, or renewed for a person in this State by a health insurer,~~
16 ~~as defined in 18 V.S.A. § 9402(8). The term shall not include benefit plans~~
17 ~~providing coverage for specific disease or other limited benefit coverage.~~

18 § 4098e. CHOICE OF PROVIDERS FOR VISION CARE AND MEDICAL

19 EYE CARE SERVICES (formerly § 4088j)

20 ~~(g)~~(a) As used in this section:

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

7 (2) “Health insurance plan” ~~means any health insurance policy or health~~
8 ~~benefit plan offered by a health insurer or a subcontractor of a health insurer,~~
9 ~~as well as Medicaid and any other public health care assistance program~~
10 ~~offered or administered by the State or by any subdivision or instrumentality of~~
11 ~~the State. The term includes~~ has the same meaning as in section 4011 of this
12 chapter and also includes vision care plans ~~but does not include policies or~~
13 ~~plans providing coverage for a specified disease or other limited benefit~~
14 ~~coverage.~~

15 (3) ~~“Health insurer” shall have the same meaning as in 18 V.S.A. §~~
16 ~~9402.~~

17 (4) “Materials” includes lenses, devices containing lenses, prisms, lens
18 treatments and coatings, contact lenses, and prosthetic devices to correct,
19 relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

1 ~~(5)~~(4) “Ophthalmologist” means a physician licensed pursuant to 26
2 V.S.A. chapter 23 or an osteopathic physician licensed pursuant to 26 V.S.A.
3 chapter 33 who has had special training in the field of ophthalmology.

4 ~~(6)~~(5) “Optometrist” means a person licensed pursuant to 26 V.S.A.
5 chapter 30.

6 ~~(7)~~(6) “Optician” means a person licensed pursuant to 26 V.S.A. chapter
7 47.

8 ~~(8)~~(7) “Vision care plan” means an integrated or stand-alone plan,
9 policy, or contract providing vision benefits to enrollees with respect to
10 covered services or covered materials, or both.

11 **(b)** To the extent a health insurance plan provides coverage for vision care
12 or medical eye care services, it shall cover those services whether provided by
13 a licensed optometrist or by a licensed ophthalmologist, provided the health
14 care professional is acting within ~~his or her~~ the health care professional’s
15 authorized scope of practice and participates in the plan’s network.

16 ~~(b)~~(c) A health insurance plan shall impose no greater co-payment,
17 coinsurance, or other cost-sharing amount for services when provided by an
18 optometrist than for the same service when provided by an ophthalmologist.

19 ~~(e)~~(d) A health insurance plan shall provide to a licensed health care
20 professional acting within ~~his or her~~ the health care professional’s scope of
21 practice the same level of reimbursement or other compensation for providing

1 vision care and medical eye care services that are within the lawful scope of
2 practice of the professions of medicine, optometry, and osteopathy, regardless
3 of whether the health care professional is an optometrist or an ophthalmologist.

4 ~~(d)~~(e)(1) A health insurer shall permit a licensed optometrist to participate
5 in plans or contracts providing for vision care or medical eye care to the same
6 extent as it does an ophthalmologist.

7 (2) A health insurer shall not require a licensed optometrist or
8 ophthalmologist to provide discounted materials benefits or to participate as a
9 provider in another ~~medical~~ health insurance or vision care plan or contract as
10 a condition or requirement for the optometrist's or ophthalmologist's
11 participation as a provider in any ~~medical~~ health insurance or vision care plan
12 or contract.

13 ~~(e)~~(f)(1) An agreement between a health insurer ~~or an entity that writes~~
14 ~~vision insurance~~ and an optometrist or ophthalmologist for the provision of
15 vision services to plan members or subscribers in connection with coverage
16 under a stand-alone vision care plan or other health insurance plan shall not
17 require that an optometrist or ophthalmologist provide services or materials at
18 a fee limited or set by the plan or insurer unless the services or materials are
19 reimbursed as covered services under the contract.

20 (2) An optometrist or ophthalmologist shall not charge more for services
21 and materials that are noncovered services under a vision care plan or other

1 health insurance plan than ~~his or her~~ the optometrist's or ophthalmologist's
2 usual and customary rate for those services and materials.

3 (3) Reimbursement paid by a vision care plan or other health insurance
4 plan for covered services and materials shall be reasonable and shall not
5 provide nominal reimbursement in order to claim that services and materials
6 are covered services.

7 (4)(A) A vision care plan or other health insurance plan shall not restrict
8 or otherwise limit, directly or indirectly, an optometrist's, ophthalmologist's,
9 or independent optician's choice of or relationship with sources and suppliers
10 of products, services, or materials or use of optical laboratories if the
11 optometrist, ophthalmologist, or optician determines that the source, supplier,
12 or laboratory ~~he or she~~ that the optometrist, ophthalmologist, or optician has
13 selected offers the products, services, or materials in a manner that is more
14 beneficial to the consumer, including with respect to cost, quality, timing, or
15 selection, than the source, supplier, or laboratory selected by the vision care
16 plan or other health insurance plan. The plan shall not impose any penalty or
17 fee on an optometrist, ophthalmologist, or independent optician for using any
18 supplier, optical laboratory, product, service, or material.

19 (B) The optometrist, ophthalmologist, or optician shall notify the
20 consumer of any additional costs the consumer may incur as the result of
21 procuring the products, services, or materials from the source, supplier, or

1 laboratory selected by the optometrist, ophthalmologist, or optician instead of
2 from the source, supplier, or laboratory selected by the vision care plan or
3 other health insurance plan.

4 (C) Nothing in this subdivision (4) shall be construed to prevent a
5 vision care plan or other health insurance plan from informing its policyholders
6 of the benefits available under the plan or from conducting an audit of an
7 optometrist's, ophthalmologist's, or optician's use of alternative sources,
8 suppliers, or laboratories.

9 (D) The provisions of this subdivision (4) shall not apply to Medicaid.

10 ~~(f)~~(g)(1) Except as otherwise specified in subdivision (f)(4), this section
11 shall apply to Medicaid and any other public health care assistance program
12 offered or administered by the State or by any subdivision or instrumentality of
13 the State.

14 (2) The Department of Financial Regulation shall enforce the provisions
15 of this section as they relate to health insurance plans and vision care plans
16 other than Medicaid.

17 * * * Conforming Revisions * * *

18 Sec. 3. 1 V.S.A. § 317(c) is amended to read:

19 (c) The following public records are exempt from public inspection and
20 copying:

1 (28) Records of, and internal materials prepared for, independent
2 external reviews of health care service decisions pursuant to ~~8 V.S.A. § 4089f~~
3 8 V.S.A. § 4063 and of mental health care service decisions pursuant to
4 ~~8 V.S.A. § 4089a~~ 8 V.S.A. § 4064.

5 * * *

6 Sec. 4. 8 V.S.A. § 4512(b) is amended to read:

7 (b) Subject to the approval of the Commissioner or the Green Mountain
8 Care Board established in 18 V.S.A. chapter 220, as appropriate, a hospital
9 service corporation may establish, maintain, and operate a medical service plan
10 as defined in section 4583 of this title. The Commissioner or the Board may
11 refuse approval if the Commissioner or the Board finds that the rates submitted
12 are excessive, inadequate, or unfairly discriminatory, fail to protect the hospital
13 service corporation's solvency, or fail to meet the standards of affordability,
14 promotion of quality care, and promotion of access pursuant to section ~~4062~~
15 4026 of this title. The contracts of a hospital service corporation that operates
16 a medical service plan under this subsection shall be governed by chapter 125
17 of this title to the extent that they provide for medical service benefits, and by
18 this chapter to the extent that the contracts provide for hospital service benefits.

19 Sec. 5. 8 V.S.A. § 4515a is amended to read:

20 § 4515a. FORM AND RATE FILING; FILING FEES

1 Every contract or certificate form, or amendment thereof, including the rates
2 proposed to be charged by the corporation, shall be filed with the
3 Commissioner or the Green Mountain Care Board established in 18 V.S.A.
4 chapter 220, as appropriate, for the Commissioner's or the Board's approval
5 prior to issuance or use. Prior to approval, there shall be a public comment
6 period pursuant to section ~~4062~~ 4026 of this title. In addition, each such filing
7 shall be accompanied by payment to the Commissioner or the Board, as
8 appropriate, of a nonrefundable fee of \$150.00 and the plain language
9 summary of rate increases pursuant to section ~~4062~~ 4026 of this title.

10 Sec. 6. 8 V.S.A. § 4516 is amended to read:

11 § 4516. ANNUAL REPORT TO COMMISSIONER

12 Annually, on or before March 1, a hospital service corporation shall file
13 with the Commissioner of Financial Regulation a statement sworn to by the
14 president and treasurer of the corporation showing its condition on December
15 31. The statement shall be in such form and contain such matters as the
16 Commissioner shall prescribe. To qualify for the tax exemption set forth in
17 section 4518 of this title, the statement shall include a certification that the
18 hospital service corporation operates on a nonprofit basis for the purpose of
19 providing an adequate hospital service plan to individuals of the State, both
20 groups and nongroups, without discrimination based on age, gender,
21 geographic area, industry, and medical history, except as allowed by

1 ~~subdivisions 4080g(b)(7)(B)(ii) and 4080g(c)(8)(B)(ii) of this title and by 33~~
2 V.S.A. § 1811(f)(2)(B).

3 Sec. 7. 8 V.S.A. § 4587 is amended to read:

4 § 4587. FILING AND APPROVAL OF CONTRACTS

5 A medical service corporation that has received a permit from the
6 Commissioner of Financial Regulation under section 4584 of this title shall not
7 thereafter issue a contract to a subscriber or charge a rate that is different from
8 copies of the contracts and rates originally filed with and approved by the
9 Commissioner at the time the permit was issued to the medical service
10 corporation, until the medical service corporation has filed copies of its
11 proposed contracts and rates and they have been approved by the
12 Commissioner or the Green Mountain Care Board established in 18 V.S.A.
13 chapter 220, as appropriate. Prior to approval, there shall be a public comment
14 period pursuant to section ~~4062~~ 4026 of this title. Each such filing of a
15 contract or the rate therefor shall be accompanied by payment to the
16 Commissioner or the Board, as appropriate, of a nonrefundable fee of \$150.00.
17 A medical service corporation shall file a plain language summary of rate
18 increases pursuant to section ~~4062~~ 4026 of this title.

19 Sec. 8. 8 V.S.A. § 4588 is amended to read:

20 § 4588. ANNUAL REPORT TO COMMISSIONER

1 Annually, on or before March 1, a medical service corporation shall file
2 with the Commissioner of Financial Regulation a statement sworn to by the
3 president and treasurer of the corporation showing its condition on December
4 31, which shall be in such form and contain such matters as the Commissioner
5 shall prescribe. To qualify for the tax exemption set forth in section 4590 of
6 this title, the statement shall include a certification that the medical service
7 corporation operates on a nonprofit basis for the purpose of providing an
8 adequate medical service plan to individuals of the State, both groups and
9 nongroups, without discrimination based on age, gender, geographic area,
10 industry, and medical history, except as allowed by ~~subdivisions~~
11 ~~4080g(b)(7)(B)(ii) and 4080g(e)(8)(B)(ii) of this title and by~~ 33 V.S.A. §
12 1811(f)(2)(B).

13 Sec. 9. 8 V.S.A. § 4724(7)(E) is amended to read:

14 (E) Making or permitting unfair discrimination between married
15 couples and parties to a civil union as defined under 15 V.S.A. § 1201, with
16 regard to the offering of insurance benefits to a couple, a spouse, a party to a
17 civil union, or their family. The Commissioner shall adopt rules necessary to
18 carry out the purposes of this subdivision. The rules shall ensure that
19 insurance contracts and policies offered to married couples, spouses, and
20 families are also made available to parties to a civil union and their families.
21 The Commissioner may adopt by order standards and a process to bring the

1 forms currently on file and approved by the Department into compliance with
2 Vermont law. The standards and process may differ from the provisions
3 contained in chapter 101, subchapter 6, and sections ~~4062~~ 4026, 4201, 4515a,
4 4587, 4685, 4687, 4688, 4985, 5104, and 8005 of this title where, in the
5 Commissioner’s opinion, the provisions regarding filing and approval of forms
6 are not desirable or necessary to effectuate the purposes of this section.

7 Sec. 10. 8 V.S.A. § 5104(a) is amended to read:

8 (a)(1) A health maintenance organization that has received a certificate of
9 authority under section 5102 of this title shall file and obtain approval of all
10 policy forms and rates as provided in sections ~~4062 and 4062a~~ 4026 and 4027
11 of this title. This requirement shall include the filing of administrative
12 retentions for any business in which the organization acts as a third party
13 administrator or in any other administrative processing capacity. The
14 Commissioner or the Green Mountain Care Board, as appropriate, may request
15 and shall receive any information that the Commissioner or the Board deems
16 necessary to evaluate the filing. In addition to any other information
17 requested, the Commissioner or the Board shall require the filing of
18 information on costs for providing services to the organization’s Vermont
19 members affected by the policy form or rate, including Vermont claims
20 experience, and administrative and overhead costs allocated to the service of
21 Vermont members. Prior to approval, there shall be a public comment period

1 pursuant to section ~~4062~~ 4026 of this title. A health maintenance organization
2 shall file a summary of rate filings pursuant to section ~~4062~~ 4026 of this title.

3 (2) The Commissioner or the Board shall refuse to approve the form of
4 evidence of coverage, filing, or rate if it contains any provision that is unjust,
5 unfair, inequitable, misleading, or contrary to the law of the State or plan of
6 operation, or if the rates are excessive, inadequate, or unfairly discriminatory,
7 fail to protect the organization's solvency, or fail to meet the standards of
8 affordability, promotion of quality care, and promotion of access pursuant to
9 section ~~4062~~ 4026 of this title. No evidence of coverage shall be offered to
10 any potential member unless the person making the offer has first been
11 licensed as an insurance agent in accordance with chapter 131 of this title.

12 Sec. 11. 8 V.S.A. § 5115 is amended to read:

13 § 5115. DUTY OF NONPROFIT HEALTH MAINTENANCE

14 ORGANIZATIONS

15 Any nonprofit health maintenance organization subject to this chapter shall
16 offer nongroup plans to individuals in accordance with 33 V.S.A. § 1811
17 without discrimination based on age, gender, industry, and medical history,
18 except as allowed by ~~subdivisions 4080g(b)(7)(B)(ii) and 4080g(c)(8)(B)(ii) of~~
19 ~~this title and by~~ 33 V.S.A. § 1811(f)(2)(B).

20 Sec. 12. 8 V.S.A. § 8083 is amended to read:

21 § 8083. EXTRATERRITORIAL JURISDICTION

1 No group long-term care insurance coverage may be offered to a resident of
2 this State under a group policy issued in another state to a group described in
3 subdivision 8082(4)(D) of this title, unless this State or another state having
4 statutory and regulatory long-term care insurance requirements substantially
5 similar to those adopted in this State has made a determination that such
6 requirements have been met. All other jurisdiction shall be pursuant to section
7 ~~4062~~ 4026 of this title.

8 Sec. 13. 8 V.S.A. § 8094(e) is amended to read:

9 (e) In the event of the death of the insured, this section shall not apply to
10 the remaining death benefit of a life insurance policy that accelerates benefits
11 for long-term care. In this situation, the remaining death benefits under these
12 policies shall be governed by sections 3731 and ~~4065~~ 4029 of this title. In all
13 other situations, this section shall apply to life insurance policies that
14 accelerate benefits for long-term care.

15 Sec. 14. 18 V.S.A. § 701 is amended to read:

16 § 701. DEFINITIONS

17 As used in this chapter:

18 * * *

19 (8) “Health ~~benefit~~ insurance plan” ~~shall have~~ has the same meaning as
20 ~~health~~ major medical insurance plan in ~~8 V.S.A. § 4088h~~ 8 V.S.A. § 4011.

21 * * *

1 Sec. 15. 18 V.S.A. § 706 is amended to read:

2 § 706. HEALTH INSURER PARTICIPATION

3 (a) As ~~provided for in 8 V.S.A. § 4088h~~ set forth in 8 V.S.A. § 4025, health
4 insurance plans shall be consistent with the Blueprint for Health as determined
5 by the Commissioner of Financial Regulation.

6 (b) Health insurers shall participate in the Blueprint for Health as a
7 condition of doing business in this State as provided for in this section and in
8 ~~8 V.S.A. § 4088h~~ 8 V.S.A. § 4025. ~~Under 8 V.S.A. § 4088h, the~~
9 ~~Commissioner of Financial Regulation may exclude or limit the participation~~
10 ~~of health insurers offering a stand-alone dental plan or specific disease or other~~
11 ~~limited benefit coverage in the Blueprint for Health. Health insurers shall be~~
12 ~~exempt from participation if the insurer only offers benefit plans that are paid~~
13 ~~directly to the individual insured or the insured's assigned beneficiaries and for~~
14 ~~which the amount of the benefit is not based upon potential medical costs or~~
15 ~~actual costs incurred.~~

16 Sec. 16. 18 V.S.A. § 4750 is amended to read:

17 § 4750. DEFINITIONS

18 As used in this chapter:

19 (1) "Health insurance plan" has the same meaning as in ~~8 V.S.A. §~~
20 ~~4089b~~ 8 V.S.A. § 4011.

21 * * *

1 Sec. 17. 18 V.S.A. § 9361(a) is amended to read:

2 (a) As used in this section, “distant site,” “health care provider,”
3 “originating site,” “store and forward,” and “telemedicine” ~~shall~~ have the same
4 meanings as in ~~8 V.S.A. § 4100k~~ 8 V.S.A. § 4089a.

5 Sec. 18. 18 V.S.A. § 9362(a) is amended to read:

6 (a) As used in this section, ~~“health~~

7 (1) “Health” insurance plan ~~and “health~~ has the same meaning as in 8
8 V.S.A. § 4011.

9 (2) “Health care provider” ~~have~~ has the same meaning as in ~~8 V.S.A. §~~
10 ~~4100l~~ and “telemedicine” 8 V.S.A. § 4098b.

11 (3) “Telemedicine” has the same meaning as in ~~8 V.S.A. § 4100k~~ 8
12 V.S.A. § 4098a.

13 Sec. 19. 18 V.S.A. § 9375(b) is amended to read:

14 (b) The Board shall have the following duties:

15 * * *

16 (6) Approve, modify, or disapprove requests for health insurance rates
17 pursuant to ~~8 V.S.A. § 4062~~ 8 V.S.A. § 4026, taking into consideration the
18 requirements in the underlying statutes, changes in health care delivery,
19 changes in payment methods and amounts, protecting insurer solvency, and
20 other issues at the discretion of the Board.

21 * * *

1 (12) ~~Review data regarding mental health and substance abuse treatment~~
2 ~~reported to the Department of Financial Regulation pursuant to 8 V.S.A. §~~
3 ~~4089b(g)(1)(G) and discuss such information, as appropriate, with the Mental~~
4 ~~Health Technical Advisory Group established pursuant to subdivision~~
5 ~~9374(e)(2) of this title. [Repealed.]~~

6 * * *

7 Sec. 20. 18 V.S.A. § 9377(g)(1) is amended to read:

8 (g)(1) Health insurers shall participate in the development of the payment
9 reform strategic plan for the pilot projects and in the implementation of the
10 pilot projects, including providing incentives, fees, or payment methods, as
11 required in this section. This requirement may be enforced by the Department
12 of Financial Regulation to the same extent as the requirement to participate in
13 the Blueprint for Health pursuant to ~~8 V.S.A. § 4088h~~ 8 V.S.A. § 4025.

14 Sec. 21. 18 V.S.A. § 9381(d) is amended to read:

15 (d) A decision of the Board's approving, modifying, or disapproving a
16 health insurer's proposed rate pursuant to ~~8 V.S.A. § 4062~~ 8 V.S.A. § 4026
17 shall be considered a final action of the Board and may be appealed to the
18 Supreme Court pursuant to subsection (b) of this section.

19 Sec. 22. 18 V.S.A. § 9404(d) is amended to read:

20 (d) There is hereby created a special fund to be known as the Green
21 Mountain Care Board Regulatory and Administrative Fund pursuant to 32

1 V.S.A. chapter 7, subchapter 5, for the purpose of providing the financial
2 means for the Green Mountain Care Board to administer its obligations,
3 responsibilities, and duties as required by law, including pursuant to ~~8 V.S.A. §~~
4 ~~4062~~ 8 V.S.A. § 4026, chapters 220 and 221 of this title, and 33 V.S.A. chapter
5 18. All fees, fines, penalties, and similar assessments received by the Board in
6 the administration of its obligations, responsibilities, and duties shall be
7 credited to the Fund. The Fund may also be used by the Department of Health
8 to administer its obligations, responsibilities, and duties as required by chapter
9 221 of this title.

10 Sec. 23. 18 V.S.A. § 9414a(a)(5) is amended to read:

11 (a) As used in this section:

12 * * *

13 (5) “Independent external review” means a review of a health care
14 decision by an independent review organization pursuant to ~~8 V.S.A. § 4089f~~ 8
15 V.S.A. § 4063.

16 * * *

17 Sec. 24. 18 V.S.A. § 9462 is amended to read:

18 § 9462. QUALITY IMPROVEMENT PROJECTS

19 ~~In addition to reviewing mental health and substance abuse treatment data~~
20 ~~pursuant to subdivision 9375(b)(12) of this title, the~~ The Green Mountain Care
21 Board shall consider the results of any quality improvement projects not

1 otherwise confidential or privileged undertaken by managed care organizations
2 for mental health and substance abuse care and treatment pursuant to ~~8 V.S.A.~~
3 ~~§ 4089b(d)(1)(B)(vii)~~ and subsection 9414(i) of this title.

4 Sec. 25. 18 V.S.A. § 9573(a) is amended to read:

5 (a) On or before December 31 of each year, the Green Mountain Care
6 Board shall review any all-inclusive population-based payment arrangement
7 between the Department of Vermont Health Access and an accountable care
8 organization for the following calendar year. The Board's review shall include
9 the number of attributed lives, eligibility groups, covered services, elements of
10 the per member, per month payment, and any other nonclaims payments. The
11 Board's review may include deliberative sessions to the same extent permitted
12 for insurance rate review under ~~8 V.S.A. § 4062~~ 8 V.S.A. § 4026.

13 Sec. 26. 32 V.S.A. § 1407(b) is amended to read:

14 (b) The State shall bear the costs of forensic medical and psychological
15 examinations administered to victims of crime committed in this State, in
16 instances where that examination is requested by a law enforcement officer or
17 a prosecuting authority of the State or any of its subdivisions and the victim
18 does not have health coverage or the victim's health coverage does not cover
19 the entire cost of the examination. The State shall also bear the costs of sexual
20 assault examinations, as defined in ~~8 V.S.A. § 4089~~ 8 V.S.A. § 4083,
21 administered to victims in cases of alleged sexual assault where the victim

1 obtains such an examination prior to receiving such a request if the victim does
2 not have health coverage or the victim’s health coverage does not cover the
3 entire cost of the examination. If, as a result of a sexual assault examination,
4 the alleged victim has been referred for mental health counseling, the State
5 shall bear any costs of such examination not covered by the victim’s health
6 coverage. These costs may be paid from the Victims’ Compensation Fund
7 from funds appropriated for that purpose.

8 Sec. 27. 32 V.S.A. § 10401 is amended to read:

9 As used in this chapter:

10 (1) “Health insurance” means any group or individual health care
11 benefit policy, contract, or other health benefit plan offered, issued, renewed,
12 or administered by any health insurer, including any health care benefit plan
13 offered, issued, renewed, or administered by any health insurance company,
14 any nonprofit hospital and medical service corporation, any dental service
15 corporation, or any managed care organization as defined in 18 V.S.A. § 9402.
16 The term includes comprehensive major medical policies, contracts, or plans;
17 short-term, limited-duration health insurance policies and contracts as defined
18 in ~~8 V.S.A. § 4084a~~ 8 V.S.A. § 4053; student health insurance policies; and
19 Medicare ~~supplemental~~ supplement insurance policies, contracts, or plans, but
20 does not include Medicaid or any other State health care assistance program in
21 which claims are financed in whole or in part through a federal program unless

1 authorized by federal law and approved by the General Assembly. The term
2 does not include policies issued for specified disease, accident, injury, hospital
3 indemnity, long-term care, disability income, or other limited benefit health
4 insurance policies, except that any policy providing coverage for dental
5 services shall be included.

6 * * *

7 Sec. 28. 33 V.S.A. § 1813(a)(2) is amended to read:

8 (2) In its review and approval of premium rates pursuant to ~~8 V.S.A.~~
9 ~~§ 4062~~ 8 V.S.A. § 4026, the Green Mountain Care Board shall ensure that:

10 * * *

11 Sec. 29. 33 V.S.A. § 1814 is amended to read:

12 § 1814. MAXIMUM OUT-OF-POCKET LIMIT FOR PRESCRIPTION
13 DRUGS IN BRONZE PLANS

14 (a)(1) Notwithstanding any provision of ~~8 V.S.A. § 4089i~~ 8 V.S.A. § 4092
15 to the contrary, the Green Mountain Care Board may approve modifications to
16 the out-of-pocket prescription drug limit established in ~~8 V.S.A. § 4089i~~ §
17 V.S.A. § 4092 for one or more bronze-level plans, as long as the Board finds
18 that the offering of such plans will not adversely impact the plan options
19 available to consumers with high prescription drug needs who benefit from the
20 out-of-pocket prescription drug limit established in ~~8 V.S.A. § 4089i~~ 8 V.S.A.
21 § 4092.

1 (2) The Department of Vermont Health Access shall certify at least two
2 standard bronze-level plans that include the out-of-pocket prescription drug
3 limit established in ~~8 V.S.A. § 4089~~; 8 V.S.A. § 4092, as long as the plans
4 comply with federal requirements. Notwithstanding any provision of ~~8 V.S.A.~~
5 ~~§ 4089~~; 8 V.S.A. § 4092 to the contrary, the Department may certify one or
6 more bronze-level qualified health benefit plans with modifications to the out-
7 of-pocket prescription drug limit established in ~~8 V.S.A. § 4089~~; 8 V.S.A.
8 § 4092.

9 (b)(1) For each individual enrolled in a bronze-level qualified health
10 benefit plan for the previous two plan years who had out-of-pocket prescription
11 drug expenditures that met the out-of-pocket prescription drug limit established
12 in ~~8 V.S.A. § 4089~~; 8 V.S.A. § 4092 for the most recent plan year for which
13 information is available, the health insurer shall, absent an alternative plan
14 selection or plan cancellation by the individual, automatically reenroll the
15 individual in a bronze-level qualified health plan for the forthcoming plan year
16 with an out-of-pocket prescription drug limit at or below the limit established
17 in ~~8 V.S.A. § 4089~~; 8 V.S.A. § 4092.

18 (2) Prior to reenrolling an individual in a plan pursuant to subdivision
19 (1) of this subsection, the health insurer shall notify the individual of the
20 insurer's intent to reenroll the individual automatically in a bronze-level
21 qualified health plan for the forthcoming plan year with an out-of-pocket

1 prescription drug limit at or below the limit established in ~~8 V.S.A. § 4089i~~ §
2 V.S.A. § 4092 unless the individual contacts the insurer to select a different
3 plan and of the availability of bronze-level plans with higher out-of-pocket
4 prescription drug limits. The health insurer shall collaborate with the
5 Department of Vermont Health Access and the Office of the Health Care
6 Advocate as to the notification’s form and content.

7 Sec. 30. 33 V.S.A. § 4110(a)(6) is amended to read:

8 (6) ~~For purposes of~~ As used in this section, “dependent coverage” ~~shall~~
9 ~~have~~ has the same meaning as in ~~8 V.S.A. § 4100b(a)(3)~~ 8 V.S.A. § 4058.

10 Sec. 31. ADDITIONAL CONFORMING REVISIONS

11 When preparing the Vermont Statutes Annotated for publication, the Office
12 of Legislative Counsel shall update any additional cross-references to statutes
13 in 8 V.S.A. chapter 107 that use the numbering scheme in effect prior to the
14 effective date of this act to conform to the new numbering scheme enacted by
15 this act.

16 * * * Interpretation and Rule Alignment * * *

17 Sec. 32. INTERPRETATION; RULE ALIGNMENT

18 (a) The purpose of this bill is to update and reorganize the health insurance
19 statutes. It is the intent of the General Assembly that the technical
20 amendments in this act shall not supersede substantive changes contained in
21 other bills enacted by the General Assembly during the current biennium.

1 Where possible, the amendments in this act shall be interpreted to be
2 supplemental to other amendments made to the sections of 8 V.S.A. chapter
3 107 using the numbering scheme in effect prior to the effective date of this act;
4 to the extent the provisions conflict, the substantive changes in other acts shall
5 take precedence over the technical changes in this act. Amendments to statutes
6 in 8 V.S.A. chapter 107 that are enacted using the numbering scheme that
7 existed prior to the effective date of this act during the 2025–2026 biennium
8 shall be codified in the corresponding statutes as renumbered by this act.

9 (b) Rules adopted and orders, bulletins, forms, and guidance documents
10 issued by the Department of Financial Regulation, the Green Mountain Care
11 Board, and other State agencies that refer to statutes in 8 V.S.A. chapter 107
12 using the numbering that existed prior to the effective date of this act shall
13 continue to be valid following the effective date of this act until such time as
14 the relevant documents can be amended or updated to align with the
15 renumbering of that chapter by this act.

16 * * * Effective Date * * *

17 Sec. 33. EFFECTIVE DATE

18 This act shall take effect on January 1, 2026.