No. 137. An act relating to miscellaneous provisions affecting health insurance regulation.

(H.489)

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

Sec. 1. 8 V.S.A. § 4062c is amended to read:

§ 4062c. COMPLIANCE WITH FEDERAL LAW

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

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

(2) The Commissioner shall enforce the requirements of the No Surprises Act as they apply to health insurers, hospital and medical service corporations, health maintenance organizations, and health care providers, to

the extent permitted under federal law, pursuant to the Commissioner's authority under this title. The Commissioner may also refer cases of noncompliance to the U.S. Department of Health and Human Services under the terms of a collaborative enforcement agreement, or to the Office of the Vermont Attorney General.

Sec. 2. NO SURPRISES ACT; PROVIDER OUTREACH

The Department of Financial Regulation, in collaboration with the Departments of Health and of Vermont Health Access and professional organizations representing health care providers, shall inform health care providers of their responsibilities under the No Surprises Act.

Sec. 3. 8 V.S.A. § 4079 is amended to read:

§ 4079. GROUP INSURANCE POLICIES; DEFINITIONS

Group health insurance is hereby declared to be that form of health insurance covering one or more persons, with or without their dependents, and issued upon the following basis:

(1)(A) Under a policy issued to an employer, who shall be deemed the policyholder, insuring at least one employee of such employer, for the benefit of persons other than the employer. The term "employees," as used ~~herein~~ in this section, shall be deemed to include the officers, managers, and employees of the employer~~,~~; the partners, if the employer is a partnership~~,~~; the officers, managers, and employees of subsidiary or affiliated corporations of a corporation employer~~,~~; and the individual proprietors, partners, and employees

of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The term "employer," as used ~~herein~~ in this section, may be deemed to include any municipal or governmental ~~corporation, unit, agency, or department thereof and the proper officers as such, of any unincorporated municipality or department thereof~~ entity or officer, or the appropriate officer for an unincorporated town or gore or for the Unified Towns and Gores of Essex County, as well as private individuals, partnerships, and corporations.

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

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

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

members ~~of one or more associations~~, or a contract or plan issued by such an association or trust~~,~~; or

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

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

~~(A)~~(I) ~~shall have~~ a minimum of 100 persons at the time of incorporation or formation ~~if it has been incorporated or formed outside this State, and a minimum of 25 persons at the time of incorporation or formation if it has been incorporated or formed in this State~~;

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

~~(C)~~(III) ~~shall have~~ been in active existence for at least one year; and

~~(D)~~(IV) ~~shall have~~ a constitution and bylaws ~~which~~ that provide that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) two or more employers;

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

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

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

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

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

Sec. 4. 8 V.S.A. § 4089f is amended to read:

§ 4089f. INDEPENDENT EXTERNAL REVIEW OF HEALTH CARE SERVICE DECISIONS

* * *

(b) An insured who has exhausted all applicable internal review procedures provided by the health benefit plan shall have the right to an independent external review of a decision under a health benefit plan to deny, reduce or terminate health care coverage or to deny payment for a health care service. The independent review shall be available when requested in writing by the affected insured, provided the decision to be reviewed requires the plan to expend at least $100.00 for the service and the decision by the plan is based on one of the following reasons:

* * *

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

* * *

Sec. 5. 18 V.S.A. § 9374(h)(5)(A) is amended to read:

(5)(A) Annually on or before September 15, the Board ~~and the Department of Financial Regulation~~ shall report to the House and Senate Committees on Appropriations the total amount of all expenses eligible for allocation pursuant to this subsection (h) during the preceding State fiscal year and the total amount actually billed back to the regulated entities during the same period. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under this subdivision.

Sec. 6. 18 V.S.A. § 9417(c) is amended to read:

(c) The Commissioner of Financial Regulation shall adopt rules pursuant to 3 V.S.A. chapter 25 to license and regulate, to the extent permitted under federal law, entities administering or proposing to administer one or more HRAs, HSAs, FSAs, or similar tax-advantaged accounts for health-related expenses, or a combination of these, in this State. The rules shall include:

(1) ~~annual~~ licensure or registration filing requirements; and

(2) such requirements and qualifications for such entities as the Commissioner determines necessary to protect Vermont consumers and employers and to help ensure that funds are disbursed appropriately.

Sec. 7. 18 V.S.A. § 9701 is amended to read:

§ 9701. DEFINITIONS

As used in this chapter:

* * *

(13) "Health care decision" means consent, refusal to consent, or withdrawal of consent to any health care and includes consent to receive out-of-network services.

* * *

Sec. 8. HEALTH INSURANCE PARITY IN RESIDENTIAL CARE FOR CHILDREN AND YOUTH WORKING GROUP; REPORT

(a) Creation. There is created the Insurance Parity in Residential Care for Children and Youth Working Group to increase access to appropriate residential treatment for children and youth who are enrolled in commercial health insurance.

(b) Membership. The Working Group shall be composed of the following members:

(1) one or more representatives from the Department of Mental Health;

(2) one or more representatives from the Department for Children and Families;

(3) one or more representatives from the Department of Financial Regulation;

(4) one or more representatives from the Agency of Education;

(5) one or more representatives from the Department of Vermont Health Access;

(6) two or more representatives from residential treatment programs, including one funded as a private nonmedical institution for residential child care and one funded through a designated or specialized service agency bundled rate, selected by the Department of Mental Health in consultation with the Department for Children and Families;

(7) two or more representatives from commercial health insurance carriers, selected by the Department of Financial Regulation; and

(8) the Chief Health Care Advocate from the Office of the Health Care Advocate or designee.

(c) Powers and duties. The Working Group shall:

(1) examine the barriers that make it difficult for children and youth to access medically necessary residential treatment;

(2) identify the reasons that Vermont residential treatment programs are resistant to becoming approved providers for private insurance;

(3) propose solutions to overcome the barriers and reasons identified pursuant to subdivisions (1) and (2) of this subsection, including the possibility of creating a common set of quality and utilization management criteria and processes for private insurance and Medicaid-funded residential treatment; and

(4) explore solutions to streamline funding options for State-placed private pay students by considering the provisions of 16 V.S.A. §§ 11 and 2950.

(d) Assistance. The Working Group shall have the administrative, technical, and legal assistance of the Department of Financial Regulation.

(e) Report. On or before December 15, 2022, the Working Group shall provide its findings and any recommendations for legislative action to the House Committees on Health Care, on Human Services, and on Education and the Senate Committees on Health and Welfare and on Education.

(f) Meetings.

(1) The Commissioner of Financial Regulation or designee shall be the Chair and shall call the first meeting of the Working Group to occur on or before June 15, 2022.

(2) A majority of the membership shall constitute a quorum.

(3) The Working Group shall cease to exist on December 15, 2022.

Sec. 9. SEPARATE INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKETS FOR PLAN YEAR 2023

(a) As used in this section, "health benefit plan," "registered carrier," and "small employer" have the same meanings as in 33 V.S.A. § 1811.

(b) Notwithstanding any provision of 33 V.S.A. § 1811 to the contrary, for plan year 2023, a registered carrier shall:

(1) offer separate health benefit plans to individuals and families in the individual market and to small employers in the small group market;

(2) apply community rating in accordance with 33 V.S.A. § 1811(f) to determine the premiums for the carrier's plan year 2023 individual market plans separately from the premiums for its small group market plans; and

(3) file premium rates with the Green Mountain Care Board pursuant to 8 V.S.A. § 4062 separately for the carrier's individual market and small group market plans.

Sec. 10. UNMERGED HEALTH INSURANCE MARKETS; REPORT

(a) The Department of Financial Regulation, in consultation with the Green Mountain Care Board, shall convene a working group of interested stakeholders to identify options for, consider the advantages and disadvantages of, and develop recommendations regarding maintaining separate individual and small group health insurance markets in future plan years in a manner that reduces premiums in the small group market without increasing costs in the individual market.

(b) On or before January 15, 2023, the Department of Financial Regulation shall provide the working group's findings and recommendations to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. 11. EFFECTIVE DATES

This act shall take effect on July 1, 2022, except that Sec. 8 (Health Insurance Parity in Residential Care for Children and Youth Working Group; report) and this section shall take effect on passage.

Date Governor signed bill: May 24, 2022