H.524

Introduced by Committee on Health Care

Date:

Subject: Health; health insurance; individual mandate; preexisting conditions; association health plans

Statement of purpose of bill as introduced: This bill proposes to implement Vermont's individual mandate to maintain health insurance coverage. It would also codify in State law certain health insurance consumer protections, including a ban on preexisting condition exclusions and a requirement to provide coverage for dependents up to 26 years of age. The bill would require looking through the structure of an association to provide health insurance plans based on the size of each underlying employer. It would prohibit licensed brokers from accepting payment for enrolling Vermont residents in certain health expense-sharing arrangements and would require the Green Mountain Care Board to quantify the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premiums. The bill would also direct the Agency of Human Services to develop strategies for increasing the affordability of health insurance and to evaluate options for the future of Vermont's health insurance markets.

An act relating to health insurance and the individual mandate

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

~~* * * Individual Mandate * * *~~

Sec. 1. 32 V.S.A. chapter 244 is amended to read:

CHAPTER 244. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE

§ 10451. DEFINITIONS

As used in this chapter:

(1) "Applicable individual" means, with respect to any month, an individual other than the following:

(A) an individual with a religious ~~conscience~~ exemption pursuant to section 10456 of this chapter;

(B) an individual not lawfully present in the United States; or

(C) an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) "Eligible employer-sponsored plan" shall have the same meaning as in 26 U.S.C. § 5000A~~, as amended,~~ and any related regulations and federal guidance, as in effect on December 31, 2017~~, and any related regulations~~.

(3) "Family size" with respect to any taxpayer means the number of individuals for whom the taxpayer is allowed a personal exemption for the taxable year under subdivision 5811(21)(C)(i) of this title.

(4) "Household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of:

(A) the taxpayer's adjusted gross income; plus

(B) the aggregated adjusted gross incomes of all other individuals who:

(i) were taken into account in determining the taxpayer's family size; and

(ii) were required to file a State tax return for the taxable year.

(5) "Minimum essential coverage" ~~shall have~~ has the same meaning as in 26 U.S.C. § 5000A~~, as amended,~~ and any related regulations and federal guidance, as in effect on December 31, 2017~~, and any related regulations~~. The term also includes any other coverage or health insurance product deemed by the Department of Financial Regulation to constitute minimum essential coverage based on the criteria established in federal law and guidance in effect on December 31, 2017.

§ 10452. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE

An applicable individual shall ensure that the individual and any dependent of the individual who is also an applicable individual is covered at all times under minimum essential coverage.

§ 10453. SHARED RESPONSIBILITY REQUIREMENT; PENALTY

(a) If a taxpayer who is an applicable individual, or any applicable individual for whom the taxpayer is liable, fails to meet the requirement to maintain minimum essential coverage set forth in section 10452 of this chapter for one or more months of the taxable year, then, unless the applicable individual qualifies for an exemption under section 10455 or 10456 of this chapter, there shall be imposed on the taxpayer a penalty in an amount determined under section 10454 of this chapter.

(b) Any penalty imposed pursuant to this chapter for any month shall be included with the taxpayer's return under chapter 151 of this title for the taxable year that includes that month.

(c) If an individual with respect to whom a penalty is imposed by this chapter for any month:

(1) is a dependent, as defined in 26 U.S.C. § 152, of another taxpayer for the taxable year including that month, the other taxpayer shall be liable for the penalty; or

(2) files a joint return for the taxable year including that month, the individual and his or her spouse shall be jointly liable for the penalty.

(d) In the event that the federal government reinstates a financial penalty for failure to maintain minimum essential coverage under 26 U.S.C. § 5000A,

the monthly penalty established by this chapter shall be suspended for each month for which the federal financial penalty is in effect.

§ 10454. AMOUNT OF PENALTY

(a) The amount of the penalty to be imposed with respect to any taxpayer with household income greater than 250 percent of the federal poverty level for any taxable year for failure to maintain minimum essential coverage shall be equal to the taxpayer's federal shared responsibility payment for the taxable year under 26 U.S.C. § 5000A and any related regulations and federal guidance, as in effect on December 15, 2017, except that the amount of the penalty to be calculated pursuant to 26 U.S.C. § 5000A(c)(1)(B) shall be determined using the Vermont average premium for bronze-level plans rather than the national average premium for bronze-level plans.

(b) Except as provided in subdivision 10453(2) of this chapter, the annualized amount of the penalty to be imposed with respect to any taxpayer with household income less than or equal to 250 percent of the federal poverty level for any taxable year for failure to maintain minimum essential coverage shall be one-half of the applicable dollar amount established for the taxable year pursuant to 26 U.S.C. § 5000A(c)(3), rounded to the nearest $5.00 increment, for each applicable individual, provided that:

(1) the amount of the penalty for an applicable individual who has not attained 18 years of age shall be one-fourth of the applicable dollar amount

established for the taxable year pursuant to 26 U.S.C. § 5000A(c)(3), rounded to the nearest $5.00 increment; and

(2) the maximum total penalty amount for a household with income less than or equal to 250 percent of the federal poverty level for any taxable year shall be 1.5 times the applicable dollar amount established for the taxable year pursuant to 26 U.S.C. § 5000A(c)(3), rounded to the nearest $5.00 increment.

§ 10455. EXEMPTIONS

No penalty shall be imposed pursuant to section 10453 or 10454 of this chapter with respect to any of the following:

(1) Individuals who cannot afford coverage.

(A) No penalty shall be imposed with respect to any applicable individual for any month if the individual's required contribution, determined on an annual basis, for coverage for the month exceeds 8.3 percent of the individual's household income for that month, as averaged over the taxable year. For purposes of this subdivision (A), the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B)(i) As used in this subdivision (1), "required contribution" means:

(I) in the case of an individual eligible to purchase minimum essential coverage through an eligible employer-sponsored plan, the portion of the annual premium that would be paid by the individual for coverage for the

individual's applicable family size, provided that the applicable family size shall not include any family member who is eligible for a medical assistance program under Title XIX (Medicaid) or Title XXI (SCHIP) of the Social Security Act; and

(II) in the case of an individual eligible only to purchase minimum essential coverage in the individual market, the annual premium for the lowest-cost bronze-level plan available through the Vermont Health Benefit Exchange for the individual's applicable family size, reduced by the amount of the federal premium tax credit for which the individual or family would be eligible under 26 U.S.C. § 36B and the amount of Vermont premium assistance available to the individual or family under 33 V.S.A. § 1812(a), provided that the applicable family size shall not include any family member who is eligible for a medical assistance program under Title XIX (Medicaid) or Title XXI (SCHIP) of the Social Security Act.

(ii) For purposes of subdivision (i)(I) of this subdivision (1)(B), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subdivision (A) of this subdivision (1) shall be made by reference to the required contribution of the employee for coverage for the applicable family size, provided that the applicable family size shall not include any family

member who is eligible for a medical assistance program under Title XIX (Medicaid) or Title XXI (SCHIP) of the Social Security Act.

(2) Taxpayers with lower income. No penalty shall be imposed with respect to any applicable individual for any month during a calendar year if the individual's household income for the most recent taxable year for which the Department of Taxes determines information is available is less than 138 percent of the federal poverty level.

(3) Members of Indian tribes. No penalty shall be imposed with respect to any applicable individual for any month during which the individual is a member of an Indian tribe as defined in 26 U.S.C. § 45A(c)(6).

(4) Months during short coverage gaps.

(A) No penalty shall be imposed for any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of three months or less. For purposes of this subdivision (4), the length of a continuous period shall be determined without regard to the calendar years in which the months of the period occurred.

(B) If a continuous period is greater than three months, no exemption shall be provided for any month in the period.

(C) If an applicable individual was not covered by minimum essential coverage for more than one continuous period of three months or less

during the same calendar year, the exemption provided by this subdivision (4) shall apply only to the months in the first of such periods.

(D) The Commissioner of Taxes, in consultation with the Commissioner of Financial Regulation, shall adopt rules pursuant to 3 V.S.A. chapter 25 for collecting the penalty imposed by sections 10453 and 10454 of this chapter in cases in which a continuous period includes months in more than one taxable year.

(5) Hardships. No penalty shall be imposed with respect to any applicable individual for any month if the individual is determined by the Commissioner of Vermont Health Access to have suffered a hardship with respect to the capability to obtain minimum essential coverage for that month. The Commissioner of Vermont Health Access shall adopt rules pursuant to 3 V.S.A. chapter 25 defining the circumstances under which an applicable individual shall be deemed to have suffered a hardship under this subdivision (5) and setting forth the process for obtaining an exemption from the penalty.

(6) Nonresidents. No penalty shall be imposed with respect to any applicable individual for any month during which the individual does not qualify for Vermont residency, as defined in subdivision 5811(11)(A) of this title.

§ 10456. RELIGIOUS EXEMPTIONS

An individual shall be exempt from the requirement to maintain minimum essential coverage and shall not be subject to a penalty under this chapter for any month if the individual has in effect an exemption from the Commissioner of Vermont Health Access certifying that the individual is:

(1)(A) a member of a recognized religious sect or division thereof that is described in 26 U.S.C. § 1402(g)(1) and is an adherent of established tenets or teachings of that sect or division; or

(B) a member of a religious sect or division thereof that is not described in 26 U.S.C. § 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the individual's religious beliefs.

(2) As used in this section, "medical health services" does not include routine dental, vision, and hearing services; midwifery services; vaccinations; necessary medical services provided to children; services required by law or by a third party; and such other services as the Commissioner of Vermont Health Access may provide in rules implementing this chapter.

§ 10457. ADMINISTRATION AND PROCEDURE

(a) Generally. The penalty provided in section 10453 and 10454 of this chapter shall be assessed by the Department of Taxes and collected in the same manner as an assessable penalty under chapter 151 of this title.

(b) Reporting coverage.

(1) Each applicable individual who files or is required to file an individual income tax return as a resident of Vermont, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the Commissioner of Taxes, whether the individual:

(A) had minimum essential coverage in effect for each of the 12 months of the taxable year for which the return is filed as required by section 10452 of this chapter, whether covered as an individual or as a named beneficiary of a policy covering multiple individuals; or

(B) claims an exemption under section 10455 or 10456 of this chapter.

(2) Unless exempted from the penalty pursuant to section 10455 or 10456 of this chapter, a penalty shall be assessed on the return if:

(A) the applicable individual fails to indicate on the return as required by subdivision (1) of this subsection (b) or indicates that he or she did not have minimum essential coverage in effect; or

(B) the applicable individual indicates that he or she had minimum essential coverage in effect, but the Commissioner of Financial Regulation determines, based on the information available to him or her, that the coverage did not constitute minimum essential coverage.

(c) Collection of penalties. The Department of Taxes shall have all enforcement and collection procedures available under chapter 151 of this title to collect any penalties assessed pursuant to this chapter. All penalties assessed pursuant to this chapter shall be deposited into the State Health Care Resources Fund established by 33 V.S.A. § 1901d.

(1) If in any taxable year, in whole or in part, a taxpayer does not comply with the requirement to maintain minimum essential coverage, the Commissioner shall retain any amount overpaid by the taxpayer pursuant to section 3112 of this title for purposes of making payments.

(2) If the amount retained pursuant to subdivision (1) of this subsection is insufficient to satisfy the penalty assessed, the Commissioner shall notify the taxpayer of the balance due on the penalty and any related interest.

(d) Appeals. Any applicable individual shall have the right to appeal a penalty collected pursuant to sections 10453 and 10454 of this chapter or the denial of an exemption pursuant to section 10455 or 10456 of this chapter.

(e) Rulemaking. The Commissioner of Taxes and the Commissioner of Vermont Health Access shall adopt rules for their respective Departments pursuant to 3 V.S.A. chapter 25 in order to carry out the purposes of this chapter.

§ 10458. DOCUMENTATION OF HEALTH INSURANCE COVERAGE

(a) An applicable individual who indicates on a Vermont income tax return that the individual had minimum essential coverage shall provide to the Department of Taxes, upon the Department's request, a copy of the statement of coverage furnished to the individual pursuant to 26 U.S.C. § 6055 by the provider of the individual's minimum essential coverage.

(b) In the event that the requirement for providers of minimum essential coverage to furnish a statement of coverage to individuals pursuant to 26 U.S.C. § 6055 is suspended or eliminated for any taxable year, the Department of Vermont Health Access and each employer, health insurance carrier, and other entity providing minimum essential coverage to residents of this State shall submit a return to the Department of Taxes including the same information as had been provided to the Internal Revenue Service pursuant to 26 U.S.C. § 6055 at such time and in such form as the Commissioner of Taxes shall require.

§ 10459. OUTREACH TO UNINSURED VERMONTERS

The Department of Vermont Health Access, in consultation with the Office of the Health Care Advocate and other interested stakeholders, shall use information obtained from the Department of Taxes regarding Vermont residents without minimum essential coverage to provide targeted outreach to

~~assist those residents in identifying and enrolling in appropriate and affordable health insurance or other health coverage.~~

Sec. 1. 32 V.S.A. chapter 244 is amended to read:

CHAPTER 244. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE

§ 10451. DEFINITIONS

As used in this chapter:

(1) "Applicable individual" means, with respect to any month, an individual other than the following:

(A) an individual ~~with a religious conscience exemption~~ who is:

(i) a member of a recognized religious sect or division thereof that is described in 26 U.S.C. § 1402(g)(1) and is an adherent of established tenets or teachings of that sect or division; or

(ii) a member of a religious sect or division thereof that is not described in 26 U.S.C. § 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the individual's religious beliefs;

(B) an individual not lawfully present in the United States; or

(C) an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) ~~"Eligible employer-sponsored plan" shall have the same meaning as in 26 U.S.C. § 5000A, as amended, and as in effect on December 31, 2017, and any related regulations.~~

~~(3)~~ "Minimum essential coverage" ~~shall have~~ has the same meaning as in 26 U.S.C. § 5000A~~, as amended,~~ and any related regulations and federal guidance, as in effect on December 31, 2017~~, and any related regulations~~. The term also includes any other coverage or health insurance product deemed by the Department of Financial Regulation to constitute minimum essential coverage based on the criteria established in federal law and guidance in effect on December 31, 2017.

§ 10452. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE

An applicable individual shall ensure that the individual and any dependent of the individual who is also an applicable individual is covered at all times under minimum essential coverage.

§ 10453. REPORTING AND DOCUMENTATION OF COVERAGE

(a) Each applicable individual who files or is required to file an individual income tax return as a resident of Vermont, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the Commissioner of Taxes, whether the individual had minimum essential coverage in effect for each of the 12 months of the taxable year for which the

return is filed as required by section 10452 of this chapter, whether covered as an individual or as a named beneficiary of a policy covering multiple individuals.

(b) An applicable individual who indicates on a Vermont income tax return that the individual had minimum essential coverage shall provide to the Department of Taxes, upon the Department's request, a copy of the statement of coverage furnished to the individual pursuant to 26 U.S.C. § 6055 by the provider of the individual's minimum essential coverage.

(c) In the event that the requirement for providers of minimum essential coverage to furnish a statement of coverage to individuals pursuant to 26 U.S.C. § 6055 is suspended or eliminated for any taxable year, the Department of Vermont Health Access and each employer, health insurance carrier, and other entity providing minimum essential coverage to residents of this State shall submit a return to the Department of Taxes including the same information as had been provided to the Internal Revenue Service pursuant to 26 U.S.C. § 6055 at such time and in such form as the Commissioner of Taxes shall require.

§ 10454. OUTREACH TO UNINSURED VERMONTERS

The Department of Vermont Health Access, in consultation with the Office of the Health Care Advocate and other interested stakeholders, shall use information obtained from the Department of Taxes regarding Vermont

residents without minimum essential coverage to provide targeted outreach to assist those residents in identifying and enrolling in appropriate and affordable health insurance or other health coverage.

Sec. 2. 32 V.S.A. § 3102(e) is amended to read:

(e) The Commissioner may, in his or her discretion and subject to such conditions and requirements as he or she may provide, including any confidentiality requirements of the Internal Revenue Service, disclose a return or return information:

* * *

(20) To the Department of Vermont Health Access for purposes of providing outreach to Vermont residents without minimum essential coverage pursuant to section 10459 of this title.

Sec. 3. 32 V.S.A. § 3112 is amended to read:

§ 3112. ALLOCATION OF PAYMENTS

(a) Any payment received by the Commissioner from any taxpayer may, notwithstanding any direction by the taxpayer to the contrary, be applied to the taxpayer's liability for any period for any tax administered by the Commissioner and for ~~any period~~ the penalty for failure to maintain minimum essential coverage pursuant to chapter 244 of this title. Any payment may, with respect to any taxable period, be applied first to the amount of any

~~interest; next to the amount of any penalty; next to the amount of any fee; and finally to the amount of any unpaid tax liability for that period.~~

~~(b) The Commissioner may treat any refund payment owed by the Commissioner to a taxpayer as if it were a payment received from the taxpayer and may apply the payment in accordance with subsection (a) of this section.~~

~~(c) The provisions of this section shall apply notwithstanding any appeal by the taxpayer.~~

Sec. 3. [Deleted.]

* * * Health Insurance Consumer Protections; Association Health Plans; Look-Through Doctrine * * *

Sec. 4. 8 V.S.A. § 4080 is amended to read:

§ 4080. REQUIRED POLICY PROVISIONS

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

* * *

(b)(1) Preexisting condition exclusions.

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

(B) As used in this subdivision (1), "group insurance policy" shall not include a policy providing coverage for a specified disease or other limited benefit coverage.

(2) Annual limitations on cost sharing.

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

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

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

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

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

(4)(A) No cost sharing for preventive services. A group insurance policy shall not impose any co-payment, coinsurance, or deductible requirements for:

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

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

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

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

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

Sec. 5. 8 V.S.A. § 4089d is amended to read:

§ 4089d. COVERAGE; DEPENDENT CHILDREN

(a) As used in this section, "health insurance plan" ~~shall mean~~ means any group or individual policy~~,~~; nonprofit hospital or medical service corporation subscriber contract~~,~~; health maintenance organization contract~~,~~; self-insured group plan, to the extent permitted under federal law; and prepaid health insurance plans delivered, issued for delivery, renewed, replaced, or assumed by another insurer, or in any other way continued in force in this State.

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

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

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

~~(2)~~(B) became so incapable prior to attainment of the limiting age; and

~~(3)~~(C) is chiefly dependent upon the employee, member, subscriber, or policyholder for support and maintenance.

~~(c)~~(2) Coverage under ~~subsection (b) of this section~~ subdivision (1) of this subsection shall not be denied any person based upon the existence of such a condition; however a health insurance plan may require reasonable periodic proof of a continuing condition no more frequently than once every year.

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

~~Sec. 6. 33 V.S.A. § 1811 is amended to read:~~

~~§ 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL EMPLOYERS~~

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

~~(1) "Health benefit plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan offered through the Vermont Health Benefit Exchange or a reflective silver plan offered in accordance with section 1813 of this title that is issued to an individual or to an employee of a~~

small employer policy, contract, certificate, or agreement offered or issued to an individual or to an employee of a small employer by a registered carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. The term includes plans offered through the Vermont Health Benefit Exchange and reflective silver plans offered in accordance with section 1813 of this title, but it does not include coverage only for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage in which benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act. The term also does not include stand-alone dental or vision benefits; long-term care insurance; short-term, limited-duration health insurance; specific disease or other limited benefit coverage; Medicare supplemental health benefits; Medicare Advantage plans; and other similar benefits excluded under the Affordable Care Act.

(2) "Registered carrier" means any person, except an insurance agent, broker, appraiser, or adjuster, who issues a health benefit plan and who has a registration in effect with the Commissioner of Financial Regulation as required by this section.

~~(3)(A) Until January 1, 2016, "small employer" means an entity which employed an average of not more than 50 employees on working days during the preceding calendar year. The term includes self-employed persons to the extent permitted under the Affordable Care Act. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week or a seasonal worker as defined in 26 U.S.C. § 4980H(c)(2)(B). An employer may continue to participate in the Exchange even if the employer's size grows beyond 50 employees as long as the employer continuously makes qualified health benefit plans in the Vermont Health Benefit Exchange available to its employees.~~

~~(B) Beginning on January 1, 2016, "small~~

"Small employer" means an entity ~~which~~ that employed an average of not more than 100 employees on working days during the preceding calendar year. The term includes self-employed persons to the extent permitted under the Affordable Care Act. The number of employees shall be calculated using the method set forth in 26 U.S.C. § 4980H(c)(2). An employer may continue to participate in the Exchange even if the employer's size grows beyond 100 employees as long as the employer continuously makes qualified health benefit plans in the Vermont Health Benefit Exchange available to its employees.

(b)(1) To the extent permitted by the U.S. Department of Health and Human Services, an individual may purchase a health benefit plan through the

Exchange website, through navigators, by telephone, or directly from a registered carrier under contract with the Vermont Health Benefit Exchange, if the carrier elects to make direct enrollment available. A registered carrier enrolling individuals in health benefit plans directly shall comply with all open enrollment and special enrollment periods applicable to the Vermont Health Benefit Exchange.

(2) To the extent permitted by the U.S. Department of Health and Human Services, a small employer or an employee of a small employer may purchase a health benefit plan through the Exchange website, through navigators, by telephone, or directly from a registered carrier under contract with the Vermont Health Benefit Exchange.

(3) No person ~~may~~ shall provide a health benefit plan to an individual or small employer unless the plan complies with the provisions of this subchapter.

(c) No person ~~may~~ shall provide a health benefit plan to an individual or small employer unless such person is a registered carrier. The Commissioner of Financial Regulation shall establish, by rule, the minimum financial, marketing, service, and other requirements for registration. Such registration shall be effective upon approval by the Commissioner of Financial Regulation and shall remain in effect until revoked or suspended by the Commissioner of Financial Regulation for cause or until withdrawn by the carrier. A carrier may withdraw its registration upon at least six months' prior written notice to

the Commissioner of Financial Regulation. A registration filed with the Commissioner of Financial Regulation shall be deemed to be approved unless it is disapproved by the Commissioner of Financial Regulation within 30 days of filing.

(d)(1) Guaranteed issue. A registered carrier shall guarantee acceptance of all individuals, small employers, and employees of small employers, and each dependent of such individuals and employees, for any health benefit plan offered by the carrier, regardless of any outstanding premium amount a subscriber may owe to the carrier for coverage provided during the previous plan year.

(2) Preexisting condition exclusions. A registered carrier shall not exclude, restrict, or otherwise limit coverage under a health benefit plan for any preexisting health condition.

(3) Annual limitations on cost sharing.

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

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

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

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

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

(5)(A) No cost sharing for preventive services. A health benefit plan shall not impose any co-payment, coinsurance, or deductible requirements for:

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

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

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

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

(B) Subdivision (A) of this subdivision (5) shall apply to a high-deductible health plan only to the extent that it would not disqualify the plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

Sec. 6. 33 V.S.A. § 1811 is amended to read:

§ 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL EMPLOYERS

* * *

(d)(1) Guaranteed issue. A registered carrier shall guarantee acceptance of all individuals, small employers, and employees of small employers, and each dependent of such individuals and employees, for any health benefit plan offered by the carrier, regardless of any outstanding premium amount a subscriber may owe to the carrier for coverage provided during the previous plan year.

(2) Preexisting condition exclusions. A registered carrier shall not exclude, restrict, or otherwise limit coverage under a health benefit plan for any preexisting health condition.

(3) Annual limitations on cost sharing.

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

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

(B)(i) In the event that the federal government does not establish an annual limitation on cost sharing for any plan year, the annual limitation on cost sharing for self-only coverage for that year shall be the dollar limit for

self-only coverage in the preceding calendar year, increased by any percentage by which the average per capita premium for health insurance coverage in Vermont for the preceding calendar year exceeds the average per capita premium for the year before that.

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

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

(5)(A) No cost sharing for preventive services. A health benefit plan shall not impose any co-payment, coinsurance, or deductible requirements for:

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

(ii) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on

Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

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

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

(B) Subdivision (A) of this subdivision (5) shall apply to a high-deductible health plan only to the extent that it would not disqualify the plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

* * *

Sec. 7. 8 V.S.A. § 4079a is amended to read:

§ 4079a. ASSOCIATION HEALTH PLANS

(a) As used in this section, "association health plan" means a policy issued to an association; to a trust; or to one or more trustees of a fund established, created, or maintained for the benefit of the members of one or more associations or a contract or plan issued by an association or trust or by a

~~iple employer welfare arrangement as defined in the Employee Retirement~~ Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

(b) The Commissioner of Financial Regulation shall adopt rules pursuant to 3 V.S.A. chapter 25 regulating association health plans in order to protect Vermont consumers and promote the stability of Vermont's health insurance markets, to the extent permitted under federal law, including rules regarding licensure, solvency and reserve requirements, and rating requirements. The Department's rules shall ensure that coverage issued to an association is rated based on the size of its underlying member employers and not on the size of the association group, such that individual members are issued individual coverage, employers with 100 or fewer employees are issued small group coverage, and employers with more than 100 employees are issued large group coverage.

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

~~*Sec. 7. [Deleted.]*~~

Sec. 7. 8 V.S.A. § 4079a is amended to read:

§ 4079a. ASSOCIATION HEALTH PLANS

* * *

(d)(1) An association health plan that provided coverage for the 2019 plan year may be renewed for coverage of existing association employer members

for subsequent plan years, to the extent permitted under federal law. An association health plan that provided coverage for the 2019 plan year shall not enroll any new employer members for coverage after the 2019 plan year; provided, however, that new employees of existing association employer members may enroll in the plan in a subsequent plan year pursuant to an offer of coverage from their employer.

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

Sec. 8. 8 V.S.A. § 4796 is amended to read:

§ 4796. COMMISSIONS; PAYMENT; ACCEPTANCE

* * *

(e) A person licensed under this chapter shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, negotiating, or otherwise orchestrating the sale, enrollment, membership, or other connection between a Vermont resident and any arrangement involving the sharing of health-related expenses that is not insurance as defined in section 3301a of this title.

* * * Health Insurance Affordability * * *

Sec. 9. HEALTH INSURANCE AFFORDABILITY; REPORT

(a) The Agency of Human Services, in consultation with interested stakeholders, shall:

(1) develop a strategy for making health insurance affordable for all Vermont residents, including younger Vermonters and Vermonters who are not eligible for financial assistance, which shall include consideration of:

(A) the maximum percentage of an individual's or family's income that the individual or family should be required to pay for health insurance premiums; *and*

~~(B) the impact of cost-sharing requirements, including deductibles, co-payments, and coinsurance, on the total cost of care that is borne by individuals with a chronic illness or condition; and~~

(B) how to link the cost of health insurance to an individual's or family's income so that no individual or family pays more than the maximum percentage identified in subdivision (A) of this subdivision (1);

(2) explore requiring individuals enrolled in the Medicaid program with income between 100 and 138 percent of the federal poverty level to pay the maximum co-payment amounts for their health care services as are allowed under federal law and investing the State funds saved in assisting Vermonters who have lower incomes with obtaining access to affordable health insurance coverage; *and*

~~(3) determine the estimated cost and appropriate mechanisms that would be needed to ensure that all Vermont residents have access to primary care~~

~~services with out-of-pocket exposure that does not exceed $10.00 per visit without requiring prior satisfaction of any applicable deductible; and~~

(3) explore the potential for establishing a regional, publicly financed, universal health care program in cooperation with other states, including identifying the opportunities and challenges that would be presented by partnering with other states to create such a program.

(b) On or before December 1, 2019, the Agency of Human Services shall submit its findings, recommendations, strategies, and estimates to the House Committees on Health Care, on Appropriations, and on Ways and Means; the Senate Committees on Health and Welfare, on Appropriations, and on Finance; the Joint Fiscal Committee; and the Health Reform Oversight Committee. The Agency shall address any need for, and feasibility of, obtaining a federal waiver of certain provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, as permitted under Section 1332 of that Act.

Sec. 10. 18 V.S.A. § 9375(d) is amended to read:

(d) Annually on or before January 15, the Board shall submit a report of its activities for the preceding calendar year to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(1) The report shall include:

* * *

(F) the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premium rates and any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged;

* * *

Sec. 11. PREMIUM ASSISTANCE EXPANSION; LEGISLATIVE INTENT

It is the intent of the General Assembly to use any revenue generated from the penalty for failure to maintain minimum essential coverage, as established in Sec. 1 of this act, to assist Vermonters who have lower incomes with obtaining access to affordable health insurance coverage.

Sec. 11. [Deleted.]

* * * Merged Insurance Markets * * *

Sec. 12. MERGED INSURANCE MARKETS; REPORT

(a) The Agency of Human Services, in consultation with interested stakeholders, shall evaluate Vermont's health insurance markets to determine the potential advantages and disadvantages to individuals, small businesses, and large businesses, including the impacts on health insurance premiums and access to health care services, of:

(1) maintaining the current health insurance market structure, in which the individual and small group markets are merged and the large group market is separate;

(2) moving to a fully merged market structure, in which individuals, small groups, and large groups are merged into a single market; and

(3) moving to a fully separated market structure, in which individuals, small groups, and large groups each purchase health insurance in a separate market.

(b) On or before December 1, 2019, the Agency of Human Services shall submit its findings and any recommendations for modifications to the current market structure to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

* * * Effective Dates * * *

Sec. 13. EFFECTIVE DATES

(a) Sec. 1 (32 V.S.A. chapter 244) shall take effect on January 1, 2020 and apply to taxable years 2020 and after.

~~(b) Secs. 2 (32 V.S.A. § 3102(e)) and 3 (32 V.S.A. § 3112) shall take effect on January 1, 2020.~~

(b) Sec. 2 (32 V.S.A. § 3102(e)) shall take effect on January 1, 2020.

(c) Secs. 4 (8 V.S.A. 4080), 5 (8 V.S.A. § 4089d), and 6 (33 V.S.A. § 1811(d)) shall take effect on January 1, 2020 and shall apply to all individual

and group insurance policies and health benefit plans issued on and after January 1, 2020 on such date as a health insurer offers, issues, or renews the policy or plan, but in no event later than January 1, 2021.

~~(d) Secs. 6 (33 V.S.A. § 1811(a)–(c)) and 7 (8 V.S.A. § 4079a) shall take effect on passage and shall apply to all health benefit plans issued, offered, or renewed for coverage on and after that date, beginning with plans for the 2020 plan year.~~

(~~e~~ *d*) Secs. *7 (8 V.S.A. § 4079a),* 8 (8 V.S.A. § 4796), 9 (health insurance affordability; report), 10 (18 V.S.A. § 9375(d)), ~~11 (premium assistance; intent),~~ 12 (merged markets; report), and this section shall take effect on passage.