

**VERMONT DEPARTMENT OF BANKING, INSURANCE AND SECURITIES
REGULATION 91-4b
MINIMUM REQUIREMENTS FOR COMPLIANCE
WITH 8 V.S.A. SECTION 4080a**

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Section 1. Purpose

The purpose of this regulation is to set forth the rules for registration of small group carriers, requirements for the sale of individual insurance and the standards and process for approval of common health care plans.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner of the Department of Banking, Insurance and Securities (“Commissioner”) by Title 8 V.S.A. Section 4080a.

Section 3. Registration

No person may offer a small group plan unless such person is a registered small group carrier as defined by 8 V.S.A. Section 4080a(a)(4). Pursuant to 8 V.S.A. Section 4080a(c), the following are the minimum requirements for registration as a small group carrier:

1. The carrier must apply to the Commissioner to be a registered small group carrier.
2. The carrier must be licensed or authorized to provide health insurance in Vermont.
3. The carrier shall have all small group rates, common health care plans and forms approved by the Department of Banking, Insurance and Securities (“Department”) prior to their use in Vermont.
4. The carrier must have licensed or employee sales representatives in Vermont.
5. The carrier must designate, in writing, the name and address of a representative responsible for answering questions and responding to complaints about underwriting and claims.
6. The carrier must provide insureds with a toll free number for claims handling and customer service.
7. All advertising material about small group insurance must clearly identify the product advertised as a “Small Group Health Insurance Plan.” All advertising material must be filed with the Department of Banking, Insurance and Securities prior to use.
8. The carrier must provide access to prior group experience, including gross premium (gross premium means written direct premium) earned premium and incurred claims, if collected, upon written request from any group policyholder.
9. The carrier must file annually the following information with the Department for the preceding calendar year no later than April 1:
 - a. the number of employers covered under each small group plan;
 - b. the number of employees and an estimate of the number of lives covered under each small group plan;
 - c. the gross premium for each small group plan;
 - d. the earned premium for each small group plan;

- e. the incurred claims for each small group plan;
 - f. the number of employers with rates deviating above and below the community rate for each small group plan;
 - g. the amount of gross premium above, below and at the community rate for each small group plan; and
 - h. the same information required in lines a-g must be provided for any business underwritten with or through an association or trust, to include the name and address of each association or trust.
10. A carrier who intends to withdraw from the small group market must notify the Commissioner in writing at least six (6) months prior to canceling or nonrenewing any coverage. This notice must include the following information:
- a. a description of the plans offered by the carrier;
 - b. the number of employers and the total number of lives insured under each contract; and
 - c. the planned termination date(s).
11. A registered carrier who qualifies under the provisions of Section 6(c), 1991, Act 52 must certify in writing by April 1 of each year that it continues to qualify and that in the preceding calendar year, it has not written more than \$100,000.00 in annual gross premium for small group business covering individuals residing in this state.

Section 4. Individual Insurance

This section sets forth the standards and process for the sale of individual insurance as required by 8 V.S.A. Section 4080a(m).

- 1. No person may sell, offer or provide a health care benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the requirements of 8 V.S.A. Section 4080a.
- 2. No person may replace, offer or solicit the replacement of an existing group contract offered by an employer by selling or offering to sell or provide individual policies to employees of that employer.
- 3. Any person offering to sell or provide individual insurance must satisfy the following requirements:
 - a. Obtain a written statement from each individual that the purchase of

individual health insurance coverage was not initiated, sponsored or subsidized by the individual's employer or any affiliate or agent of the employer.

- b. Obtain a written statement from each agent or broker selling an individual policy that the sale was not made as a means of circumventing small group health insurance and that the purchase was not initiated, sponsored or subsidized by the individual's employer or any affiliate or agent of the employer.
- c. Retain and make available for the Department's inspection all documentation required in subsections 3(a) and (b) for at least three (3) years.
- d. Provide to the Department no later than April 1 of each year the following information for the preceding calendar year:
 - i. the number of individuals covered under all policies;
 - ii. the total gross premium for all policies;
 - iii. the total earned premium;
 - iv. the total incurred claims;
 - v. the percentage increase or decrease in new policies issued and existing policies renewed; and
 - vi. the total number of policies issued.

Section 5. Common Health Care Plans

This section sets forth the standards and process for approval of common health care plans as required by 8 V.S.A. Section 4080a(e).

1. Standards and Criteria.

The following standards and criteria shall be considered by the Commissioner in approving common health care plans. The standards and criteria are to be used as guidelines. They are not intended to establish minimum benefit levels or outlines of policy coverage that must be included in a common health care plan.

- a. **Comparable** – a common health care plan shall permit comparison of the costs and relative benefits of all plans available to consumers.
- b. **Affordable** – a common health care plan shall balance specific benefits and benefit levels with their impact on the plan cost. Cost containment

features such as deductibles, co-insurance and managed care should be considered.

- c. Style and terms of policy – a common health care plan shall be easy for a consumer to read and understand. It shall contain a clear description of benefits, exclusions and conditions. A carrier may use its own format and style of type, subject to the Department’s approval.
- d. Exceptions and reductions – any exceptions or reductions of coverage shall be clearly labeled as such in a separate section of the plan. Each specific exclusion shall be listed and identified by number. Appropriate notice and explanation for each reduction or exclusion shall be provided to certificateholders.
- e. Managed benefits – the suitability of requiring managed benefits shall be considered for each plan. Managed benefits may include but are not limited to pre-admission certification, admission certification of emergency admissions, concurrent review and individual case management.
- f. Preventative care – each plan shall consider the use of preventative care benefits to promote the general health of certificateholders.
- g. Benefit component – each benefit plan shall weigh the needs of Vermonters for the broadest benefit package possible, considering the constraints imposed by the cost of each benefit on the overall plan.
- h. Feasibility – each plan will be considered in light of the technical and logistical requirements imposed on registered small group carriers.

2. Required Policy Provisions

Each common health care plan must satisfy the following minimum policy provisions:

- a. Cancellation and Nonrenewal.
 - i. A carrier who cancels or nonrenews a group health insurance policy or subscriber contract shall:
 - (a) notify the group policyholder or other entity involved, and each of its employees or members covered under the policy or subscriber contract of the date of termination of the policy or contract. The notice shall advise the employees or members that, unless otherwise provided for in the policy or contract, the carrier shall not be liable for claims

for losses incurred after the termination date and shall direct employees or members to refer to their certificates or contracts in order to determine their rights. The obligation to notify employees or members shall not apply to associations, trusts, and groups other than employer groups if the addresses of the employees and members are not reasonably available to the carrier. A carrier is not obligated to provide notice to employees and members if the termination of the policy or contract is due to replacement coverage subject to the provisions of this subchapter.

employee

(b) advise, in any instance in which the plan involves

contributions, that if the policyholder or other entity continues to collect contributions for coverage beyond the date of termination, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.

ii. Except for cases pursuant to subsection (a) of this section, whenever the carrier is obligated to give any notice to employees and members directly, the carrier shall prepare and furnish to the policyholder or other entity a supply of notice forms to be distributed to covered employees or members. The forms shall state the fact of termination and the effective date of termination. The forms shall contain a statement directly employees or member to refer to their certificates or contracts in order to determine their rights. The notice forms shall be provided at the time the carrier gives its notice of termination to the policyholder or other entity.

b. Pre-existing Conditions.

For a 12-month period from the effective date of coverage, a registered small group carrier may limit coverage for pre-existing conditions which existed during the 12-month period preceding the effective date of coverage except that a registered small group carrier shall waive any pre-existing conditions for all new employees or members of a small group, and their dependents, who produce evidence of continuous health benefit coverage (whether group or non-group) during the previous nine months which is substantially equivalent to the common health care plan of the carrier approved by the Commissioner.

c. Continuation and Conversion.

Any employee or member whose insurance under a group policy would

terminate because of the termination of employment or the death of a covered employee shall be entitled to continue coverage under the policy as provided in Chapter 107, Subchapter 2 of Title 8. In addition, such person shall be entitled to have a converted policy as provided in Chapter 107, Subchapter 2 of Title 8. The converted policy shall cover any person who was covered by the continued group policy. At the option of the insurer, a separate, converted policy may be issued to cover any dependent. Premiums charged shall not exceed 102 percent (102%) of the group rate.

d. Termination and Replacement.

Carriers must comply with Title 8 V.S.A., Chapter 107, Subchapter 3 for the termination and replacement of coverage.

e. Mandated Benefits.

Except as stated in the model plan, no policy can be issued or delivered or advertised unless the following minimum benefits are available:

- i. Mental health care, with the minimums stated in 8 V.S.A., Section 4089 must be offered as an option.
- ii. Dependent children coverage must be provided where coverage would otherwise end for a child at a limiting age. There shall be no limit or coverage restriction for a child who is incapable of employment and dependent on the employee or member for support and maintenance. See 8 V.S.A. Section 4090.
- iii. Newborn coverage must be provided without notice or additional premiums for 31 days after birth. Coverage shall include well
baby
care, injury, sickness, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as provided at 8 V.S.A. Section 4092
- iv. Home health care coverage with the minimums provided in 8 V.S.A., Sections 4095 and 4096 must be offered as an option.
- v. Alcoholism treatment must be provided for the necessary care and treatment of alcohol dependency as required by 8 V.S.A. Section 4098.
- vi. Coverage for screening by low-dose mammography must be provided according to 8 V.S.A. Section 4100a.

vii. Maternity coverage must be provided and shall be treated as any other sickness for all insureds covered by the policy as required under Regulation 89-1.

f. Process for Approval of Common Health Care Plans.

i. Advisory Committee.

(a) The Commissioner shall appoint at least seven members to a small group health plan advisory committee. The committee shall include individuals representing business, the general public, the insurance industry, and the medical community. To the greatest extent possible, committee members will have technical expertise in health care insurance or regulation.

(b) The Commissioner shall consult with the small group advisory committee in the development of small group benefit plans, revision of existing plans and review of plan suitability.

(c) The Committee will review all proposed plans for compliance with the standards set forth in Section 1.

ii. Review of suitability.

The Commissioner, in consultation with the advisory committee, will annually review the suitability of all approved common health care plans. This review will consider the number of policies sold during the prior year, the cost of the plan(s) and the need for any amendments to the plan(s). Any plan deemed unsuitable will be withdrawn, as required by the Commissioner.

iii. Process of approval.

(a) Upon approval of a common health care plan, the Commissioner shall:

(1) notify all registered small group carriers and supply a copy of the common health care plan;

- (2) prepare a consumer guide to the benefit plan within six months of approval; and
 - (3) publish semi-annually the rates charged by carriers for each common health care plan.
- (b) A registered small group carrier shall offer all approved common health care plans within six months of approval of the plan by the Commissioner.

Effective: November 1, 1992