STATE OF VERMONT

DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

Division of Health Care Administration

ADOPTED RULE H-2008-05

Health Insurance Programs Promoting Wellness

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SECTION ONE. POLICY

(a) Authority

This Rule is promulgated pursuant to Titles 8 and 18 of the Vermont Statutes Annotated, The Health Care Affordability Act of 2006 (Act 191, 2005, Adj. Sess.), An Act Relating to Health Care Reform (Act 203, 2007, Adj. Sess.) and other applicable law.

(b) Policy

Health care costs continue to rise in excess of the rate of inflation and these rising costs create hardships to all Vermonters. Effective use of preventive care and chronic care management is needed to prevent or slow the progress of chronic disease and reduce disease complications. Reducing major health risks such as poor diet, lack of physical activity, tobacco use, and alcohol and substance abuse will stem the rising incidence of chronic diseases linked to these factors over the long term.

(c) Scope

This Rule applies to all health insurance policies and contracts, whether issued by a health insurer, a nonprofit medical or hospital service corporations, or a health

maintenance organization. This Rule does not apply to coverage for specified disease or other limited benefits, Medicare Supplement, long term care, or workers compensation.

SECTION TWO. DEFINITIONS

Definitions included in Title 8, chapter 107 are incorporated herein by reference.

(a) "Blueprint" shall mean the Blueprint for Health established pursuant to Chapter 13 of Title 18 of the Vermont Statutes Annotated.

(b) "Care management program" means a written plan created by a health care practitioner to reduce the modifiable risk factors identified in a health risk assessment or in the practitioner's evaluation. Such care management programs shall be consistent with applicable standards in Section 5 of this Rule.

(c) "Carrier" as used in this Rule shall refer to both registered nongroup carriers, registered small group carriers and other entities authorized to offer health insurance in Vermont.

(d) "Chronic care" means health services, including medication, provided by a health care professional for an established clinical condition that is expected to last a year or more that requires ongoing clinical management attempting to restore the individual to the highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

(e) "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, system supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications, utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

(f) "Commissioner" means the Commissioner of the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

(g) "Department" means the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

(h) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

(i) "Health service" means any medically necessary treatment or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services offered by a health care professional and medically necessary services to assist in activities of daily living.

(j) "Nongroup plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract or a health maintenance organization health benefit plan offered or issued to an individual. The term does not include disability insurance policies, accident indemnity or accident expense policies, long-term care insurance policies, student expense or student indemnity policies, athletic expense or athletic indemnity policies, Medicare supplement policies, and dental policies. The term also does not include hospital indemnity policies or specified disease indemnity or expense policies provided such policies are sold only as supplemental coverage to a comprehensive health insurance policy in effect.

(k) "Insured" means any individual covered by any health insurance policy or contract governed by this Rule, including subscribers, members, policyholders, certificate holders, spouses and dependents.

(l) "Preventive care" means health services provided by health care professionals to preclude, identify or treat conditions in asymptomatic individuals, including those who have developed risk factors or preclinical disease but in whom the disease is not clinically apparent, and including immunizations, screening, counseling, treatment and medication determined by scientific evidence to be effective in preventing or detecting a condition.

(m) "Primary care" means health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and shall include prenatal care and the treatment of mental illness.

(n) "Registered nongroup carrier" means any person or other entity, except an insurance producer, appraiser or adjuster, who issues a nongroup plan and who has registration in effect with the Commissioner as required by 8 V.S.A. § 4080b.

(o) "Registered small group carrier" means any person or other entity, except an insurance producer, appraiser or adjuster, who issues a small group plan and who has registration in effect with the Commissioner as required by 8 V.S.A. § 4080a.

(p) "Small group plan" means a group health insurance policy, a nonprofit hospital or medical service corporation service contract or a health maintenance organization health benefit plan offered or issued to a small group.

(q) "Small group" means a small employer or an association, trust or other group issued a health insurance policy as defined by 8 V.S.A. § 4080a.

(r) "Split benefit design" means a health insurance plan, including a small group plan, with two or more benefit levels in which the premium for all levels is the same, but the benefits differ in the amount of co-payments, co-insurance, deductibles, out-of-pocket maximums, or a combination of these options.

(s) "Wellness criteria" means the health measures, such as body mass index or cholesterol levels, related to modifiable risk factors which an insured must satisfy in order to be eligible for preferred benefits in a split benefit plan. Such criteria shall be consistent with any such measures established by the Department, the Vermont Department of Health or the Blueprint.

(t) "Wellness program" as used in this Rule means a program of health promotion and disease prevention offered by a carrier in conjunction with a health insurance plan as provided for in Section 3 or Section 4 of this Rule.

SECTION THREE. HEALTHY CHOICES DISCOUNTS

(a) Except as expressly allowed by this Rule, all nongroup and small group health insurance plans shall be community rated consistent with applicable law, including Department rules and bulletins.

(b) Consistent with this Rule, registered small group and nongroup carriers may deviate from the community rate by establishing rewards, premium discounts, rebates or otherwise waiving or modifying applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by an insured to specified programs of health promotion and disease prevention.

(i) Programs for health promotion and disease prevention which are the basis for deviation from a carrier's community rate shall be subject to review and approval by the Commissioner.

(ii) Programs for health promotion and disease prevention shall be administered consistent with Section 5 of this Rule.

(iii) Any discount or other reward subject to this Rule shall be offered to all similarly situated individuals.

(iv) Consistent with other applicable state and federal laws, a discount or other reward shall not be premised on an individual achieving a specified health status, but it may be premised on specific program participation obligations.

(c) Nongroup carrier deviations from the community rate as allowed by Section 3(b) above shall limit any reward, discount, rebate or waiver or modification of cost sharing to no more than a total of 15 percent of the cost of the premium for the specific benefit package. In no event shall a nongroup carrier deviate from its community rates by more than 30 percent, including all allowable rating factors. For the purpose of calculating appropriate percentages, deviations based on differences in rewards, deductibles, co-insurance, or other cost-sharing shall be measured by the actuarial value of such differences.

(d) Small group carrier deviations from the community rate as allowed by Section 3(b) above shall limit any reward, discount, rebate or waiver or modification of cost sharing to no more than a total of 15 percent of the cost of the premium for the specific benefit package. In no event shall a carrier deviate from its community rates by more than 20 percent, including all allowable deviations rating factors. For the purpose of calculating appropriate percentages, deviations based on differences in rewards, deductibles, co-insurance, or other cost-sharing shall be measured by the actuarial value of such differences.

(i) A small group carrier shall not combine in the same health plan the healthy choices discounts under this Section 3 with a split benefit plan design as provided for under Section 4 below.

SECTION FOUR. GROUP HEALTH INSURANCE SPLIT BENEFIT PLANS

(a) Carriers, including small group carriers, may offer group health insurance plans with a split benefit design. Plans shall provide coverage for primary care, preventive care, chronic care, acute episodic care, and hospital services.

(b) Subject to this Section 4, all small group health insurance plans shall be community rated consistent with Department rules relating to small group insurance minimum standards and other applicable law.

(c) Notwithstanding Section (4)(b) above and Department rules relating to small group and nongroup insurance minimum standards and other applicable law, a registered small group carrier may deviate from the community rate as provided in this Section 4.

(d) Consistent with this Rule, a registered small group carrier may offer health insurance plans with a split benefit design.

(i) Split benefit design health insurance plans shall be administered to promote health and prevent disease and shall be administered consistent with Section 5 below.

(ii) Split benefit design health plans, including programs of health promotion and disease prevention included in the administration of such plans, shall be subject to review and approval by the Commissioner.

(e) Each product with a split benefit design shall provide two benefit levels, to be known as a basic benefit and preferred benefit. Both benefit levels shall provide for a waiver of the deductible and other cost sharing payments for preventive care.

(i) All insureds shall receive the preferred benefit for the first 6 months after enrollment.

(ii) In order to continue to be eligible for the preferred benefit beyond the initial period, within the first six months after enrollment, adult insureds shall:

(A) choose a primary care provider;

(B) complete a validated health risk assessment adopted by the Commissioner upon recommendation from the Director of the Blueprint;

(C) meet with his or her primary care practitioner for an evaluation, at which time the practitioner shall assess the insured for the following modifiable risk factors:

(1) tobacco use;
(2) high blood pressure;
(3) lipid profile;
(4) diabetes; and

(5) obesity.

(iii) The carrier shall make the health risk assessment available to the insured in both an online and paper version and shall transmit a copy of the results to the insured's primary care practitioner.

(v) For any modifiable risk factor which has been found by the practitioner to fail to meet the established wellness criteria, the primary care practitioner shall develop, with the participant, a written plan for a healthier lifestyle or other care management program to address the modifiable risk factors.

(A) Wellness criteria shall be consistent, to the extent applicable, with the Blueprint. For the five modifiable risk factors noted in Section (4)(e)(ii)(C) above, the Director of the Blueprint shall define acceptable values for each factor. These values shall be published by the Commissioner.

(B) Upon request, the practitioner may submit a copy of the written plan, if any, to the carrier.

(vi) Upon completion of the requirements of subsection (e)(ii) above, insureds who meet the wellness criteria or commit to participation with the health care practitioner's written care management plan and any chronic care management plans offered by the carrier for the insured's chronic conditions (if any), shall continue to receive the preferred benefit. An insured who does not comply with the requirements of subsection (e)(ii) above, or who does not satisfy the carrier's wellness criteria and is unwilling to comply with the written care management plan and applicable chronic care management plans, shall only be eligible for the basic benefit package after expiration of the 6 month period following initial enrollment.

(A) Written care management plans shall only mandate health care services covered by the carrier. Written care management plans may include recommendations to take steps or obtain services which are not covered by the carrier; but such steps or services shall not be required to maintain preferred benefits. Nothing in this subsection should be construed to mean that care management plans cannot include activities that do not constitute health care services, such as exercise. Written care management plans should take into consideration an insured's physical, economic, cultural, or other unique circumstances.

(B) Chronic care management programs must be offered by the carrier and be accessible to the insured in order for such programs to be a prerequisite for preferred level benefits. A carrier shall not disqualify an individual from preferred benefits for failure to participate in a chronic care management program unless the carrier has affirmatively sought to enroll the individual in the program and the individual has affirmatively declined to participate.

(vii) In order to remain eligible for the preferred benefit beyond the six months of initial enrollment, insureds shall:

(A) Complete a new health risk assessment each year;

(B) Meet with his or her primary care practitioner annually or as otherwise directed by the primary care practitioner;

(1) Upon a showing of scheduling difficulties beyond the insured's reasonable control, a carrier shall allow deviations from the mandated timelines for health care practitioner visits. Such allowable deviations shall permit the insured at least 3 months extra to meet with his or her health care practitioner.

(C) Have his or her primary care practitioner complete and submit to the carrier a common validated wellness checklist adopted by the Director of the Blueprint documenting the insured's status with respect to meeting applicable wellness criteria, as well as documenting the insured's compliance with the written care management plan and complying with any applicable chronic care management plan; and

(D) If the insured still does not meet the carrier's wellness criteria, commit to participation in a new care management plan created with the insured by his or her practitioner. Such commitment may be in the form of a standard statement signed by the insured. In order to maintain preferred benefits, insureds must also participate in any chronic care management programs for which they are eligible.

(viii) If two people are married or partners in a civil union, and both adults are insured under one policy, both insured adults must meet the requirements of this subsection in order for the couple or family to be eligible for the preferred benefit. Failure of one or both adults to meet any or all of the requirements shall render all members ineligible for the preferred benefit.

(ix) At least annually, a carrier shall provide an opportunity for a insured to qualify for preferred benefits. Carriers shall provide at least 90 days notice to an insured of when an opportunity to become eligible for preferred benefits shall be available.

(x) To assess preferred or basic benefit levels, a carrier may evaluate an insured's compliance with his or her care management plan no more than once every three months.

(x) The carrier shall establish a written process, to be approved by the Commissioner, to handle appeals from insureds regarding whether the insured is entitled to basic or preferred benefits.

(e) A registered small group carrier shall be permitted to require that if an employer elects to offer a split benefit design product, the employer only offer a split benefit design product to its employees. A registered small group carrier shall be permitted to require that an association or individual members of an association, if electing to offer a split benefit design product, shall offer only a split benefit design product to its members or employees. Nothing in this Rule should be construed to allow carriers to require that an employer or association offer split benefit design products.

(f) Carriers may require employers offering employees split benefit designs to commit to a healthy work environment. Such requirements shall be consistent with any standards or recommendations published or adopted by the Vermont Department of Health or the Blueprint.

(g) Any health care professional that agrees to accept a carrier's split benefit design product or products shall not balance bill the insured by charging the insured amounts in addition to the reimbursement provided for by the carrier's participating provider agreement.

SECTION FIVE. RULES APPLICABLE TO ALL WELLNESS PROGRAMS

(a) Programs of health promotion and disease prevention subject to this Rule shall be designed and administered consistent with this Section 5.

(b) Wellness programs shall focus on health promotion and disease prevention. Wellness programs shall not be used as a subterfuge for imposing higher costs on an individual based on a health factor. Wellness programs shall be based on scientific, evidence-based medical practices, and be consistent with the most current guidance from Vermont Department of Health, the U.S. Preventive Services Task Force, the Agency for Healthcare Research and Quality and the National Business Group on Quality. Consistent with the goals of Act 203 (2007 Session, Adj. Sess.), it is understood that Commissioner, with input from the Commissioner of Health, may update by Bulletin the appropriate sources for guidance as necessary.

(c) Wellness programs shall create appropriate opportunities and incentives for employers, health care practitioners, and insureds to engage in healthy behaviors, including:

(i) focusing on primary care, prevention and wellness;

(ii) actively managing the chronically ill population in connection with the activities of section 702 of Title 18; and

(iii) using evidence-based medical practices.

(d) Wellness programs may include, but not be limited to, incentives for insureds to:

(i) engage in recommended health screenings such as for blood glucose or cholesterol;

(ii) utilize health promotion services, such as nutrition education or chronic disease self management assistance; and

(iii) utilize disease prevention services, such as smoking cessation and weight loss programs.

(e) Carrier standards and procedures for evaluating an individual's adherence to an established wellness program shall be subject to approval by the Commissioner. Such an evaluation program shall be created and administered consistent with

applicable state and federal laws prohibiting discrimination based on a health factor, and may include mechanisms such as reviews of claims data to determine whether insureds receive particular health promotion and disease prevention services and verification of participation in health promotion or disease prevision programs. Successful adherence to a wellness program shall not be premised on a insured achieving a specified health factor.

(f) Any financial or other incentives provided pursuant to a wellness program shall be offered to all similarly situated individuals.

(g) Wellness programs shall provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the wellness program benefit. Carriers shall disclose in all materials that describe or reference the wellness program the availability of a reasonable alternative standard. In lieu of providing an alternative, a carrier may choose to allow an individual the wellness program benefit without the individual's participation in the program.

(h) Wellness programs may not base rewards or other benefit on the achievement of a health status factor.

(i) All wellness programs, including written care management programs or chronic care management programs, shall be consistent with the Blueprint.

(j) Carriers shall provide insureds with written information about the wellness program, including:

(i) how insureds may participate in the program;

(ii) the rewards or other benefits for participating in the program;

(iii) how to access health promotion and disease prevention services (including reasonable alternatives available);

(iv) how an insureds adherence to wellness program will be evaluated; and

(v) a clear statement that the wellness program does not base rewards or other benefits on the achievement of a specified health factor.

SECTION SIX. RATE AND FORM APPROVAL PROCESSES

(a) Except as expressly stated herein, carriers shall develop rates and forms under this Rule consistent with 8 V.S.A. § 4062, Chapters 107, 123, 125 and 139 of Title 8, Small Group and Nongroup Insurance Minimum Standards and all procedures applicable to other rate and form filings.

(b) Premium rates for split benefit designs shall target a 10 percent reduction in rates below the premium of a comparable product in the preferred benefit level in the relevant market. The difference between the actuarial value of the benefit levels shall be no greater than 20 percent, and carriers shall not be permitted to impose additional rate deviations beyond the 20 percent allowed for the split benefit design.

EFFECTIVE DATE.

These rules shall take effect on January 14, 2009.