

**STATE OF VERMONT  
AGENCY OF HUMAN SERVICES  
Department of Vermont Health Access (DVHA)**

**AHS Bulletin No: 15-01P**

Secretary of State's ID Number: 15P-066

**FROM:** Steven M. Costantino, Commissioner  
Department of Vermont Health Access

**DATE:** 12/14/2015

**SUBJECT:** 8200 - Authority for Qualified Health Plan and Stand-Alone Dental Plan Certification

**CHANGES ADOPTED EFFECTIVE:** 03/15/2016

**TYPE OF RULE CHANGE**

Adopted Rule Change

Final Proposed Rule Change

Proposed Rule Change

**RULE REFERENCE(S): 8200**

The Department of Vermont Health Access (DVHA) is filing a permanent administrative rule that sets forth requirements for certification and de-certification of Qualified Health Plans (QHPs) and Stand-Alone Dental Plans (SADPs) on the Vermont Health Benefit Exchange (or Vermont Health Connect). It provides administrative standards for QHPs and SADPs in areas including: customer service, materials and marketing, enrollment and eligibility, and premium payment. Some of these requirements are necessary for reporting to the federal government. The proposed rule also provides for important administrative due process in the case a certification or decertification action is taken against an issuer by DVHA. Finally, the proposed rule outlines requirements for consumer direct enrollment in QHPs offered outside the Vermont Health Benefit Exchange, in accordance with Act 54 of 2015 Vermont Legislative Session.

***Specific Changes to Rule Sections***

Section	Description of Change
8200	<p>New rule added to Medicaid administrative rules. Rule reads:</p> <p>8200 <u>Authority for Qualified Health Plan and Stand-Alone Dental Plan Certification</u> (3/15/2016, 15-01P)</p> <p>(1) Under 33 V.S.A. §§ 1810, 1811 (f)(2)(A), (B) and (C), the Commissioner of the Department of Vermont Health Access (DVHA) has a specific duty to create rules for the operation of the Vermont Health Benefit Exchange (VHBE).</p> <p>Under 33 V.S.A. §§ 1805, 1806 the Commissioner of DVHA has an implicit duty to promulgate rules regarding the operation of the VHBE.</p>

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Alone Dental Plan

8200.1 Definitions (3/15/2015, 15-01P)

(A) The following words shall have the definition found in federal law or federal law under the Affordable Care Act regulations or are defined by state law relating to the operation of the VHBE<sup>1</sup>:

**Advance Payment of Premium Tax Credit (APTC)**

**Cost Sharing**

**Essential Community Providers**

**Essential Health Benefit (EHB) Package**

**Federal Tax Information**

**Individual Market**

**Issuer**

**Personally Identifiable Information**

**Protected Health Information**

**Qualified Health Plan (QHP)**

**Small Business Health Options Program (SHOP)**

**Small Group Coverage**

**Special Enrollment Period**

**Stand-Alone Dental Plan (SADP)**

(B) If a word defined below is also defined in the Vermont Rules for Health Benefits Eligibility and Enrollment under 13 Vt. Code R. 170-001 (hereafter HBEE 1.0 et seq.), the definition below shall take precedence over the definition found in the HBEE.

**Coverage** means scope of health benefits provided to an enrollee.

**DFR** means the State of Vermont Department of Financial Regulation.

**DVHA** means the Department of Vermont Health Access.

**Grace Period** means that period of time specified by the law following the premium due date during which coverage remains in force and an enrollee or employer may pay the premium without penalty or termination of coverage.<sup>2</sup>

**GMCB** means the Green Mountain Care Board.

**Standard Plan** means a plan design approved by the GMCB.

<sup>1</sup> In the order listed above, definitions are located as follows: 45 C.F.R. §155.20; 45 C.F.R. §155.20; 45 C.F.R. §156.235; 45 C.F.R. §156.20; [IRS Publication 1075](#); 45 C.F.R. §144.103; 45 C.F.R. §144.103; [OMB Memorandum M-07-16](#); 45 C.F.R. §160.103; 45 C.F.R. §155.20 and 33 V.S.A. § 1802(7); 45 C.F.R. §155.20; 45 C.F.R. §159.110; 45 C.F.R. §155.20; 45 C.F.R. §156.400.

<sup>2</sup> See 45 C.F.R. § 156.270.

**Non-Standard Plan** means a plan designed by an Issuer.

**Tier** means, for a particular QHP or SADP policy, the number and type of individuals covered (e.g. single person, family, adult plus dependent).

8200.2 Vermont Health Benefit Exchange Certification Procedure  
(3/15/2016, 15-01P)

8200.2.1 Submission of New and Continuing Plans for Certification

(A) DVHA will offer direction to Issuers annually following approval of Standard Plan offerings by the GMCB and, in advance of the DFR form filing, regarding any changes or special circumstances affecting requirements for Standard and Non-Standard Plan offerings. Such direction shall be posted on DVHA's website.

(B) Issuers seeking certification of a QHP for the individual market or SHOP must:

1. Have a license in good standing from the DFR,
2. Have plan forms approved by the DFR,<sup>3</sup> and
3. Have plan rates approved by the GMCB.<sup>4</sup>

(C) Issuers seeking certification of a SADP must:

1. Have forms approved by the DFR,
2. Have rates approved by the DFR, and
3. Have registration and license from the DFR.

(D) After licensure, rate review and form review is completed, in accordance with subsections B and C above, all information is submitted by the DFR and GMCB to DVHA for certification or recertification.<sup>5</sup>

(E) For new Issuers of either QHPs or SADPs, the Issuer must submit a "Letter of Intent to Offer a Product on the VHBE". Such letter must be received by the Commissioner of DVHA by November 30<sup>th</sup> two years before the benefit year it wishes to offer a plan. For example, for an Issuer to offer a product beginning January 1, 2017, the letter must be received by November 30, 2015 (two years before the beginning of the benefit year). Such letter must specify whether the Issuer intends to submit certification proposals for Standard and Non-Standard QHPs, or whether the Issuer intends to submit a SADP proposal. In addition, the letter must identify the organization's primary operational, technical and executive contacts needed during the initial set-up and certification

<sup>3</sup> 8 V.S.A. § 4062 (h).

<sup>4</sup> 8 V.S.A. § 4062, 80 Vt. Code R. 280-002 2.00.

<sup>5</sup> 33 V.S.A. § 1805(1)(A); 33 V.S.A. § 1806; 42 U.S.C. § 18031(c); 45 C.F.R. 155 Subpart K; 45 C.F.R. 156 Subpart C.

process.

(F) Subsequent to submission of the “Letter of Intent to Offer a Product on the VHBE”, the Issuer must complete all certification steps outlined within this rule following the established annual timeline. Non-timely submission may be cause for DVHA to deny plan certification.

**8200.2.2 Certification Requirements for Qualified Health Plans or Stand-Alone Dental Plans**

(A) Each Issuer of a QHP or SADP must:

1. Comply with 33 V.S.A. § 1806, 45 C.F.R. 155 Subpart K, 45 C.F.R. 156 Subpart C, 45 C.F.R. Part 92 and other requirements listed in this rule,
2. Comply with Standards for Issuers, in 7800.3 below,
3. Comply with Standards for Plan Design, in Rule 7800.4,
4. Comply with Administrative Standards, in Rule 7800.6, and
5. Conform with other laws, including those listed in Rule 7800.7.

(B) A QHP or SADP shall be certified if the Commissioner of DVHA finds, in his or her discretion, that:

1. The plan is affordable,
2. The plan promotes high quality care, disease prevention and wellness,
3. The plan promotes access to health care,
4. The Issuer participates in the State’s health care reform efforts,
5. The plan meets such other criteria as DVHA deems appropriate, such as receipt of a “Letter of Intent to Offer a Product on the VHBE”,
6. The plan’s certification has not expired, and
7. Issuer and plan are in compliance with applicable state and federal laws, including 7800.3, 7800.4, and 7800.6 of this Rule.

**8200.2.3 Certification Determination of Qualified Health Plans**

(A) Health plans which are found to meet the GMCB and DFR qualifications will be transmitted to DVHA for a certification decision.

(B) Subject to subsection C below, a QHP shall be certified for at least one plan year.

(C) DVHA may independently review plans to assess continued compliance with the minimum certification requirements.

**8200.2.4 Certification Determination of Stand-Alone Dental**

Plans

(A) SADPs which are found to meet the DFR qualifications will be transmitted to DVHA for a certification decision.

(B) Subject to subsection C below, a SADP shall be certified for at least one plan year.

(C) DVHA may independently review plans to assess continued compliance with the minimum certification requirements.

8200.3     Standards for Issuer Offerings                     (3/15/2016, 15-01P)

8200.3.1     Standards for Issuers of Qualified Health Plans

(A) The Issuer shall offer at least the following for QHP certification consideration:

1.     Each Standard Plan approved by the GMCB, and<sup>6</sup>
2.     One catastrophic plan.

(B) Issuer shall offer the following selection of Non-Standard Plans:

1.     At the bronze, silver and gold metal levels, and
2.     May offer additional plans at its discretion.

(C) DVHA may request additional Non-Standard Plan submissions from carriers at their discretion. DVHA will post such requests on DVHA's website.

(D) For each QHP, the Issuer shall make available a "child only" option, or agree to issue the plan to children even in the absence of a parent covered by the policy.

(E) The Issuer shall be accredited with respect to the performance of its QHPs by an accrediting agency approved by the Department of Health and Human Services.<sup>7</sup> Issuers who do not have an accreditation in place from the previous year must receive accreditation within a reasonable timeframe as determined by the VHBE.

(F) The Issuer complies with the requirements of participation in Blueprint for Health.

(G) Issuer must make its plans available to a service area encompassing every ZIP code within the State of Vermont.

8200.3.2                     Standards for Issuers of Stand-Alone Dental

<sup>6</sup> 33 V.S.A. § 1806 (e)(1)(B).

<sup>7</sup> 42 U.S.C. § 18031 (c)(1)(D); 45 C.F.R. § 156.275; 33 V.S.A. § 1806 (c)(1).

Plans

(A) The following is required of any Issuer to have a SADP certified:

1. Is licensed under state law and are in good standing with the DFR,
2. Meets the annual limitation on cost sharing, demonstrates the offering of pediatric dental essential health benefits, and provides an actuarial value certification,<sup>8</sup> and
3. Makes its plans available to a service area encompassing every ZIP code within the State of Vermont.

(B) Pediatric dental plans must provide coverage with no cost share for Class I services (except in high deductible health plans), 30% for Class II services and 50% for Class III services as defined in the Children's Health Insurance Program (dental benchmark). Plans offered by dental carriers shall incorporate any future modifications necessary to comply with specific threshold amounts the Centers for Medicare & Medicaid Services or DVHA chooses to adopt.

8200.4 Standards for Plan Design (3/15/2016, 15-01P)

8200.4.1 Standards for Qualified Health Plan Design

(A) For each QHP, Issuer has demonstrated during the registration, form review, or rate review process, or as detailed under state and federal law, that the plan:

1. Provides an EHB package,
2. Employs cost sharing limitations required for the applicable level of coverage,
3. Provides coverage that meets the actuarial value requirements of the applicable coverage level within required tolerances,
4. Maintains an adequate provider network that includes required Essential Community Providers,
5. Provides appropriate services to enable access for underserved individuals and populations,
6. Meets the quality measures requirements of 42 U.S.C. § 18031(h),
7. Meets the QHP Issuer rate and benefit information requirement of 45 C.F.R. § 155.1020,
8. Meets standards for participation in Blueprint for Health, and
9. Complies with applicable law pertaining to privacy and security of federal tax information, personally identifiable information and protected health information.

8200.4.2 Standards for Stand-Alone Dental Plan Design

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<sup>8</sup> 45 C.F.R. § 156.150.

(A) For each SADP, Issuer has demonstrated during the registration or rate review process, or as detailed under state and federal law, that the plan:

1. Provides the pediatric dental essential health benefit as defined in 42 U.S.C. § 18022 (b)(1)(J) of the Affordable Care Act and approved by the VHBE,
2. Provides coverage that meets the actuarial value requirements within required tolerances,
3. Maintains an adequate provider network that includes required Essential Community Providers or receives exemption from this requirement by the federal government,
4. Meets the quality measures requirements of 42 U.S.C. § 18031 (h),
5. Meets the Issuer rate and benefit information requirement of 45 C.F.R. § 155.1020, and
6. Complies with applicable law pertaining to privacy and security of federal tax information, personally identifiable information and protected health information.

#### 8200.5 Enrollment (3/15/2016, 15-01P)

##### 8200.5.1 Acceptance

(A) Issuers shall accept enrollment transactions from the VHBE for individuals following established eligibility determinations. Enrollment transactions shall meet technical specifications as provided by DVHA.

(B) At the VHBE's option or until such time as federal permission is withdrawn, Issuers will conduct direct enrollment of qualified employers and employees under SHOP following established eligibility determinations, including coverage and effective dates.

##### 8200.5.2 System of Record

(A) The VHBE shall be considered the system of record for effective dates of coverage.

##### 8200.5.3 Billing and Enrollment Timeline

(A) Issuers must follow the provisions of the billing and enrollment document outlining enrollment and premium billing requirements. The document will be posted on DVHA's website.

##### 8200.5.4 Termination for Non-Payment

(A) Issuers must terminate QHP coverage for non-payment of premiums after a grace period. Issuers shall process other

termination of coverage transactions as directed by the VHBE, in accordance with HBEE 43.00 and 76.00.

8200.5.5 Reconciliation

(A) QHP Issuers shall provide a file to allow the VHBE to reconcile files for qualified individuals at least once per month as initiated by the VHBE. Issuers must provide the following data elements to the VHBE each month:

- Social Security Number,
- Subscriber identification number,
- Enrollee identification (Issuer),
- Supplemental identification number (VHBE),
- Date of birth,
- Gender,
- Street address, city, state, ZIP,
- Plan identifier (health information oversight identification number),
- Coverage level,
- Coverage effective date,
- Small group identification number,
- Total premium,
- APTC amount,
- APTC effective date,
- Federal Cost Sharing Reduction (CSR) amount,
- Federal CSR effective date,
- State CSR amount, and
- State CSR effective date.

(B) Data transfer will be secure as provided in the QHP Data Sharing Agreement.

(C) Rules 7800.5.1 to 7800.5.5 do not apply in the context of direct enrollment outside the VHBE under Rule 7800.5.9.

8200.5.6 Cost Share Credit for Transferring Enrollees, Including Direct Enrollees

(A) If, during a calendar year, an individual enrolls in a different QHP from the same QHP Issuer as a result of a Special Enrollment Period, cost sharing paid by the individual during the same calendar year shall be combined for both QHPs for purposes of the calculation of the deductibles and annual limitations on cost sharing.

(B) The provisions in subsection A above regarding the calculation of deductibles and annual limits on cost sharing will also apply for an individual transferring between individual and small group coverage or between small groups, provided that the individual enrolls in the same QHP, including Issuer, Metal Level, and Tier.

8200.5.7 Direct Enrollment for Individual Market

(A) A QHP Issuer may directly enroll an individual into a QHP pursuant to 33 V.S.A. § 1811(b).

(B) The only products available for direct enrollment are QHPs certified under this Rule 7800.2.3.

8200.5.8 Direct Enrollment in Qualified Health Plan Through Vermont Health Benefit Exchange<sup>9</sup>

(A) The Commissioner of DVHA may authorize a QHP Issuer to conduct direct enrollment in a QHP in a manner that is considered to be through the VHBE consistent with federal regulations and technical specifications.

(B) The Commissioner of DVHA will grant such authorization to a QHP Issuer in writing and post it on DVHA's website.

8200.5.9 Direct Enrollment in Qualified Health Plan Outside Vermont Health Benefit Exchange

(A) In the absence of authorization to conduct direct enrollment in a manner that is considered to be through the VHBE under Rule 7800.5.8, the direct enrollment of an individual into a QHP shall be considered enrollment outside the VHBE.

(B) Direct enrollment in a QHP outside the VHBE precludes the availability of the federal premium tax credit, Vermont Premium Assistance, or federal or Vermont cost-sharing reductions.

(C) A QHP Issuer offering direct enrollment outside the VHBE shall:

1. Inform applicants that no subsidy is available to direct enrollees, and
2. Refer applicants to the VHBE website for enrollment in a subsidy-eligible QHP.

(D) A QHP Issuer offering direct enrollment under Rule 7800.5.9 subsection A shall comply with all open enrollment and Special Enrollment Periods and effective dates applicable to the VHBE.

(E) A QHP Issuer shall credit cost-sharing in accordance with Rule 7800.5.6 if a customer transitions between the Issuer's QHP through the VHBE and the Issuer's QHP outside the VHBE.

8200.6 Required Administrative Standards for Issuers  
(3/15/2016, 15-01P)

<sup>9</sup> 45 CFR § 156.1230

### 8200.6.1 Technical Requirements

(A) Issuer's website will link to the VHBE website for eligibility determinations.

(B) With the exception of SADP Issuers, each Issuer's website will link to a subsidy calculator tool located on the VHBE website.

(C) Issuer will provide staff and resources necessary for full cooperation in bi-directional testing deployment and maintenance of, or changes to, VHBE systems with reasonable notice by the VHBE.

### 8200.6.2 Customer Service

(A) Issuers must provide support and information requested by the VHBE to enable the timely and complete resolution of customer complaints and inquiries relating to issues including claims, coverage status, payment, and reported changes to customer information.

(B) Issuers must make available customer service representatives during normal business hours to assist enrolled consumers with claims related inquiries.

(C) Issuers must track and report monthly on the performance of its customer service call center, including:

- Total calls received,
- Answer rate (including percentage of calls answered within 24 seconds, 30 seconds, and 240 seconds),
- Abandonment rate,
- Single call resolution rate, and
- Rate of calls referred to the VHBE.

(D) Each report shall include the entire month's metrics and shall be sent on the first Monday of the following month to the email address: [AHS.DVHAVHCEO@vermont.gov](mailto:AHS.DVHAVHCEO@vermont.gov).

### 8200.6.3 Materials and Marketing

(A) The following materials may not be disseminated or published by an Issuer unless submitted to the VHBE for approval 14 days in advance:

1. Public communication and correspondence to QHP enrollees, former enrollees, potential enrollees, businesses and their employees regarding SHOP which relate to the QHPs, SADPs or the activities and workings of the VHBE.
2. Materials using the copyrights and trademarks of the VHBE or featuring logos or symbols created by the VHBE.
3. Materials containing incidental references to the VHBE programs or activities may be disseminated without prior

approval, but final copies must be sent to the VHBE in accordance with these Rules.

(B) Review is not required of an Issuer's general or promotional materials, including non-VHBE specific advertising, employer or employee newsletters, unless such materials refer to the VHBE. Review is not required for ad hoc communications intended for a specific enrollee or a specific subset of enrollees with a unique situation.

(C) Explanations of benefits or coverage and claims documents are not materials subject to the prior approval requirements outlined above in Rule 7800.6.3 subsection A.

1. The VHBE has the right to disapprove or require changes to materials described in the prior approval requirements of Rule 7800.6.3 subsection A. The VHBE has the right to disapprove of such materials in the event the State reasonably determines such materials are misleading, inaccurate or non-compliant with law. The VHBE will:
  - a. Communicate approval or disapproval with within seven days,
  - b. Give reasons for any disapproval or changes required, and
  - c. Notify Issuers if more time is needed to review materials.
2. Issuers must send final copies of approved materials at least one business day in advance of dissemination to the email address: [AHS.DVHAVHCEO@vermont.gov](mailto:AHS.DVHAVHCEO@vermont.gov). Marketing and communications activities by Issuers will comply with federal and state standards concerning those with Limited English Proficiency and the disabled population.
3. Issuers may not alter or substitute the VHBE logo and symbols denoting certification or approval by the VHBE.
4. All enrollee identification cards, with the exception of cards for individuals who have directly enrolled in a QHP outside the VHBE under Rule 7800.5.9, shall contain the VHBE logo and a toll-free number unique to enrollees. The card shall include the phone number of the VHBE Customer Support line for the Individual Market or SHOP, as applicable.
5. Issuers shall provide access to a provider directory for each plan year and update such provider directory, at their discretion, to assure access to care.

8200.6.4 Reporting of Enrollment Data to Vermont Health Benefit Exchange

(A) For direct enrollment in the individual market, each Issuer shall

provide a report each month that demonstrates aggregate enrollment data as of the first Saturday of the month for the number of individuals directly effectuated in a QHP and currently enrolled as of a given plan year, by:

- Overall total,
- Product,
- Metal Level  
(Platinum/Gold/Silver/Bronze/Catastrophic),
- Tier (Single/Couple/Head of Household/Family),
- Gender (Male/Female),
- Age (<18, 18-25, 26-34, 35-44, 45-54, 55-64, ≥65),
- Gender and age (<18M, 18-25M, 26-34M, 35-44M, 45-54M, 55-64M, ≥65M, <18F, 18-25F, 26-34F, 35-44F, 45-54F, 55-64F, ≥65F),
- County (breakout by 14 counties),
- Renew versus new, and
- Language preference.

(B) For SHOP, each Issuer shall provide a report each month, using a template provided by the State, that demonstrates the following information as of the first Saturday of the month (or as federally specified):

- Number of employers who completed an application through SHOP,
- Total number of employers who selected a QHP/metal level for a given plan year through SHOP,
- New employers: Number of employers selecting a QHP/metal level for a given plan year through SHOP who were not enrolled in a SHOP QHP for the previous plan year,
- Re-enrolled employers: Number of employers selecting a QHP/metal level for a given plan year through SHOP who were enrolled in a SHOP QHP for the previous plan year,
- Total number of SHOP enrolled employers during the current coverage year,
- New employers: Number of new SHOP enrolled employers,
- Re-enrolled employers: Number of re-enrolled SHOP employers,
- Number of employers offering dependent coverage,
- Number of employers offering employee choice,
- Average employer premium contribution percentage,
- Number of employees enrolled through SHOP,
- Number of employees on employee roster submitted by employers,
- Number of employees (covered lives, including dependents) enrolled through SHOP, and
- Other metrics as federally defined or re-defined.

(C) Reports shall be sent on the Monday following the first Saturday of the month (or as federally specified) to the email address:

[AHS.DVHAVHCEO@vermont.gov](mailto:AHS.DVHAVHCEO@vermont.gov).

(D) The VHBE may request additional enrollment information to be provided in a timely manner including, but not limited, to monthly aggregate dunning and termination statistics.

#### 8200.6.5 Premium Processing

(A) In the Individual Market, the VHBE collects premiums for QHPs purchased through the VHBE and forwards the aggregated premiums to the respective Issuer weekly, with an additional remittance on the last business day of each month.

(B) In the event that payment is made directly to an Issuer for a QHP purchased through the VHBE, the Issuer must forward such payment to the VHBE.<sup>10</sup>

1. Payments for premiums will be reconciled monthly between the Issuer and the VHBE.
2. Each Issuer shall provide a monthly report of any payments received for a QHP purchased through the VHBE.

(C) The VHBE shall establish policies regarding termination of coverage for failure to pay premium and such policy shall be posted on the VHBE website.

(D) For direct enrollment, the Issuer shall collect premiums from enrollees.

(E) For SHOP, the Issuer must establish a policy for the termination of employer group health coverage at the request of the employers and a policy regarding termination of coverage for non-payment of premiums. The VHBE shall approve such policies, and the VHBE and Issuers shall post such policies on their websites. Issuers are responsible for collection of premium from individuals and small business employers terminated for non-payment according to established grace period rules.

(F) QHP issuers shall be responsible for any collections of outstanding premiums for an enrollee who has been terminated from VHC coverage.

#### 8200.6.6 Appeals

(A) Issuers shall hear any enrollee health care or dental coverage appeals.

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<sup>10</sup> 45 C.F.R. § 155.240 (a).

(B) Should VHBE documents or personnel be necessary to assist the Issuer in an appeal, the VHBE shall provide such documents and personnel.

(C) If an appeal is filed by an enrollee to the VHBE, the Issuer shall cooperate and provide documents and witnesses as is necessary to adjudicate the appeal.

(D) The VHBE may provide an informal hearing and resolution to all appeals.

8200.7 Compliance with Other Laws (3/15/2016, 15-01P)

(A) Throughout this rule, the VHBE has expressly noted the compliance with certain laws. The inclusions of these citations do not negate the application of other requirements of the Affordable Care Act, the Medicaid Act, and the DFR or GMCB.

8200.8 Termination, Non-Renewal or De-Certification of Qualified Health Plan or Stand-Alone Dental Plan (3/15/2016, 15-01P)

8200.8.1 Process for Appeal of an Action

(A) The termination, non-renewal or decertification of a QHP or SADP shall be denoted as an “action” in this part of the rule.

(B) If the VHBE determines, based on its own investigation or another Department’s investigation, that a QHP no longer complies with the requirements of this rule, the VHBE may take an “action”.

(C) To take an “action”, a notice will be generated by the VHBE that provides the following:

1. The action being taken,
2. The effective date of the action,
3. The reasoning, including legal authority and jurisdiction, for the action,
4. A citation to, or the process for, resolution of the action, and
5. The date, time and place of the hearing for the action.

(D) The Commissioner of DVHA may make a more detailed statement of issues at a later date.

(E) Prior to taking an “action”, the VHBE may issue a notice of non-compliance to the Issuer. A notice of non-compliance shall contain:

1. A notice of the problem that the VHBE is experiencing,
2. A citation to the authority to correct the problem,
3. A time period for correction by the Issuer, and
4. An opportunity to provide, or a request for, a corrective

action for the non-compliance.

(F) A notice of non-compliance and corrective action is not appealable.

(G) Nothing in this rule prohibits the parties from informally resolving an “action” prior to a hearing.

(H) The Issuer may appeal an “action”.

1. An appeal is commenced by a letter to the Commissioner of DVHA, filed in the Commissioner’s office, within thirty (30) days of receipt of notice of the “action”. The letter shall state the reasons for appealing the “action”. Should the letter fail to explain the reasons for the appeal, the Commissioner may request additional information to explain the reasoning of the appeal. Such request will not make the receipt of the appeal untimely.
2. The appeal shall be considered a “contested case” under 3 V.S.A. § 809.
3. After receipt of the appeal, DVHA shall appoint a hearing examiner.
4. The hearing examiner will manage the case to hearing, conduct the hearing and make recommendations to the Commissioner.

8200.8.2 Issuer Withdraw of Qualified Health Plan or Stand-Alone Dental Plan

(A) In the event an Issuer withdraws a QHP or SADP because of insolvency or receivership, such Issuer shall advise the VHBE through the Commissioner of DVHA immediately upon notice of either proceeding.

(B) The Issuer shall work with state officials at DVHA, DFR and GMCB with regard to notice to its members, its plan operations, the payment of claims, and the continued obligation for reporting of data to the VHBE.

(C) In the event an Issuer ends coverage of a QHP or SADP for any reason, such termination does not end its obligation to process and pay claims or its responsibility to provide reporting to the VHBE under these Rules.

***Public Hearing and Comments***

A public hearing is scheduled on Friday, January 22, 2016 from 12:00 PM to 2:00 PM in the Agency of Human Services (AHS), 208 Hurricane Lane, Suite 103, Williston, Vermont.

Written comments may be submitted no later than 4:30 pm on Friday, January 29, 2016 to Lindsay Parker, Medicaid Policy Unit, Agency of Human Services, 312 Hurricane Lane, Williston, Vermont 05495, via email:

[ahs.medicaidpolicy@vermont.gov](mailto:ahs.medicaidpolicy@vermont.gov), or by Fax: (802) 871-3084.

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To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Department of the Vermont Secretary of State at: <http://vermont-archives.org/aparules/index.htm> or call Louise Corliss at 828-2863. [General information, not specific rule content information]

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For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: <http://legislature.vermont.gov/committee/detail/2016/39> or contact Charlene Dindo at [charlene@leg.state.vt.us](mailto:charlene@leg.state.vt.us).