
Standards for Issuers Participating in the Vermont Health Benefit Exchange

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Under 33 V.S.A. § 1810, the Agency of Human Services may adopt rules to carry out the duties and functions of the Vermont Health Benefit Exchange. The following rules provide standards for Issuers offering Qualified Health Plans and Stand-Alone Dental Plans on the Vermont Health Benefit Exchange, as well as standards for Qualified Health Plans.

8201 Definitions

This section defines terms used throughout rules 8200-8208:

- (A) Advance payments of premium tax credit (APTC) has the same meaning as “advance payments of the premium tax credit” as defined at 45 C.F.R. § 155.20.
- (B) Cost sharing has the same meaning as “cost sharing” as defined at 45 C.F.R. § 155.20.
- (C) Coverage means scope of health benefits provided to an enrollee.
- (D) DFR means the State of Vermont, Department of Financial Regulation.
- (E) DVHA means the State of Vermont, Department of Vermont Health Access.
- (F) Essential community providers means providers that serve predominately low-income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by section 221 of Public Law 111-8.
- (G) Essential health benefits (EHB) package has the same meaning as “essential health benefits package” as defined at 45 C.F.R. § 156.20.

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- (H) Federal Tax Information has the same meaning as “federal tax information” as defined in IRS Publication 1075.
- (I) GMCB means the State of Vermont, Green Mountain Care Board.
- (J) 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.¹
- (K) Individual market has the same meaning as “individual market” as defined at 45 C.F.R. § 144.103.
- (L) Issuer has the same meaning as “issuer” as defined at 45 C.F.R. § 144.103.
- (M) Non-Standard Plan means a plan designed by an issuer.
- (N) Personally Identifiable Information (PII) means personally identifiable information in any medium, including electronic, which can be used to distinguish or trace an individual’s identity, such as his/her name, social security number, biometric records, etc., either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as date and place of birth, or mother’s maiden name.
- (O) Protected Health Information (PHI) has the same meaning as “protected health information” as defined at 45 C.F.R. § 160.103.
- (P) Qualified Health Plan (QHP) has the same meaning as “qualified health plan” as defined at 45 C.F.R. § 155.20 and must meet the standards for qualified health benefit plans set out in 33 V.S.A. § 1806.
- (Q) Qualified Individual is an individual who has been determined eligible to enroll in a QHP through the VHBE under 45 C.F.R § 155.20 and HBEE 3.00.
- (R) Small Business Health Options Program (SHOP) has the same meaning as “small business health options program” as defined at 45 C.F.R. § 155.20.
- (S) Small Group Coverage has the same meaning as “small group coverage” as defined at 45 C.F.R. § 159.110.
- (T) Special Enrollment Period has the same meaning as “special enrollment period” as defined at 45 C.F.R. § 155.20.
- (U) Stand-Alone dental plan (SADP) has the same meaning as “stand-alone dental plan” as defined at 45 C.F.R. § 156.400.
- (V) Standard Plan means a plan design approved by the GMCB.
- (W) Tier means, for a particular QHP or SADP policy, the number and type of individuals covered (e.g., single person, family, adult plus dependent).
- (X) Vermont Premium Reduction (or VPA) means that premium assistance provided pursuant to 33 V.S.A § 1812(a).
- (Y) Termination, non-renewal, or decertification of a QHP or SADP means a formal proceeding taken by DVHA that prevents an Issuer from offering a plan on the VHBE. This term does not include a notice of noncompliance or compliance inquiry.

¹ See 45 C.F.R. § 156.270.

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8202 Vermont Health Benefit Exchange Certification

Only QHPs may be offered in the small group and individual market. All QHPs and SADPs must be certified by DVHA.

8202.1 Certification of QHPs8202.1.1 Issuer Standards for Qualified Health Plan Offerings

In order to be eligible for QHP certification:

- (A) The Issuer must have a Vermont license in good standing with DFR.
- (B) The Issuer must be accredited with respect to the performance of its QHPs by an accrediting agency approved by the Department of Health and Human Services. An Issuer that does not have an accreditation in place from the previous year must receive accreditation within a reasonable timeframe as determined by the VHBE.
- (C) The Issuer must comply with the requirements of participation in Blueprint for Health.
- (D) The Issuer must make its plans available to a service area encompassing every ZIP code within the State of Vermont.
- (E) The Issuer must offer each Standard Plan approved by the GMCB, including at each metal level.²
- (F) The Issuer must offer the following selection of Non-Standard Plans:
 - a. At the bronze, silver (including all mandated cost share reduction levels as approved by DFR) and gold metal levels, and
 - b. One catastrophic plan

In the event an Issuer is unable to obtain DFR approval of a specific existing Non-Standard Plan design due to federal or state regulation, the Issuer may continue to offer remaining approved metal levels for that Non-Standard Plan.

- (G) For each QHP, the Issuer must 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.
- (H) The Issuer may offer to DVHA additional plans at its discretion.
- (I) DVHA may request additional Non-Standard Plan submissions from Issuers at their discretion. DVHA will post such requests on DVHA’s website and notify current and prospective QHP Issuers thereof.

8202.1.2 Standards for Qualified Health Plan Designs

Each QHP must:

- (A) Provide an EHB package;
- (B) Employ cost sharing limitations required for the applicable level of coverage;

² 33 V.S.A. § 1806(e)(1)(B).

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- (C) Provide coverage that meets the actuarial value requirements of the applicable coverage level within required tolerances;
- (D) Maintain an adequate provider network that includes required Essential Community Providers;
- (E) Provide appropriate services to enable access for underserved individuals and populations;
- (F) Meet the quality measure requirements pursuant to 45 C.F.R. § 156, Subpart L;
- (G) Meet the QHP Issuer rate and benefit information requirement of 45 C.F.R. § 155.1020;
- (H) Meet standards for participation in Blueprint for Health; and
- (I) Comply with applicable law pertaining to privacy and security of federal tax information, personally identifiable information and protected health information.

8202.1.3 Submission of Qualified Health Plans for Certification

- (A) Annually, DVHA will publish a comprehensive certification timeline prior to the start of the QHP certification cycle for the following benefit year. For example, the certification timeline for the 2018 plan year shall be distributed to the Issuers and posted on DVHA’s website by fall 2016.
 1. The certification timeline shall include all known deadlines for tasks required in order to be eligible for certification consideration, including the filing of forms with DFR, the filing of rates with GMCB, and all necessary templates and other documentation required by state or federal law.
 2. The certification timeline may be amended in response to changing regulatory requirements, although DVHA shall work to ensure that Issuers have sufficient notice to comply with such requirements.
 3. At DVHA’s discretion, the certification timeline may include policy direction and requests intended to further the State’s health policy goals.
- (B) Issuers that did not offer a QHP on the Vermont Health Benefit Exchange in the previous year 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 30th two years before the benefit year it wishes to offer a plan. For example, for an Issuer to offer a product beginning January 1, 2018, the letter must be received by November 30, 2016. Such letter must specify whether the Issuer intends to submit certification proposals for Standard and Non-Standard QHPs. In addition, the letter must identify the organization’s primary operational, technical and executive contacts needed during the initial set-up and certification process. Non-timely submission may be cause for DVHA to deny plan certification.
- (C) For all Issuers seeking certification, following approval of Standard Plan designs by the GMCB and in the advance of the DFR form filing, DVHA will notify Issuers of any changes or special circumstances affecting requirements for Standard Plan designs. Such direction will be communicated to current and prospective Issuers and posted on DVHA’s website.
- (D) After licensure, form review and rate review is completed, all QHP information is submitted by the DFR and GMCB to DVHA for certification or recertification.³

8202.1.4 Certification Determination of Qualified Health Plans

³ 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.

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- (A) A QHP will be certified under 33 V.S.A. § 1806(A) if the Commissioner of DVHA finds 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."
- (B) DVHA shall not use its discretion in subsection (A) to deny certification of all Non-Standard Plans of a QHP issuer.
- (C) Subject to DVHA's termination authority, a QHP will be certified for at least one plan year.
- (D) DVHA will notify an Issuer of plan certification prior to open enrollment.⁴ Such notice will identify certified standard and non-standard plans.
- (E) In the case of recertification of an existing QHP, DVHA will notify an Issuer of plan recertification at least two weeks prior to open enrollment.⁵

8202.2 Certification of Stand-Alone Dental Plans8202.2.1 Issuer Standards for SADPs

In order to be eligible for SADP certification, the issuer must:

- (A) Have a license in good standing from the DFR;
- (B) Have forms approved by the DFR;
- (C) Have rates approved by the DFR;
- (D) Offer one or more products meeting federal actuarial value requirements.⁶

8202.2.2 Standards for Stand-Alone Dental Plan Design

- (A) For each SADP, the Issuer has demonstrated during the form 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. Meets the annual limitation on cost sharing, demonstrates the offering of pediatric dental essential health benefits, and provides an actuarial value certification,⁷
 3. Makes its plans available to a service area encompassing every ZIP code within the State of Vermont,
 4. Maintains an adequate provider network that includes required Essential Community Providers or receives exemption from this requirement by the federal government,
 5. Meets the quality measures requirements of 45 C.F.R. § 156, Subpart L,
 6. Meets the Issuer rate and benefit information requirement of 45 C.F.R. § 155.1020, and

⁴ 45 C.F.R. § 155.1010(a)(1).

⁵ 45 C.F.R. § 155.1075(b).

⁶ 45 C.F.R. § 156.150.

⁷ 45 C.F.R. § 156.150.

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7. Complies with applicable law pertaining to privacy and security of federal tax information, PII, and PHI.
- (B) Pediatric dental plans must provide coverage with no cost sharing for Class I services (except in high deductible health plans), 30% co-insurance for Class II services and 50% co-insurance for Class III services as defined in the Children's Health Insurance Program (dental benchmark).
- (C) Plans offered by dental carriers must incorporate any future modifications necessary to comply with specific threshold amounts the Centers for Medicare & Medicaid Services or DVHA chooses to adopt.

8202.2.3 Submission of SADPs for Certification

- (A) Annually, DVHA will publish a comprehensive certification timeline prior to the SADP certification cycle for the following benefit year. For example, the certification timeline for the 2018 plan year shall be distributed to the Issuers and posted on the DVHA's website by fall 2016. Such certification timelines shall be distributed to all Issuers offering SADP's on the VHBE and shall also be published on the DVHA website.
1. The certification timeline shall include all known deadlines for tasks required in order to be eligible for the certification consideration, including the filing of forms with DFR and all necessary templates and other documentation required by federal law.
 2. The certification timeline may be amended in response to changing regulatory requirements, although DVHA shall work to ensure Issuers have sufficient notice to comply with such requirements.
 3. At DVHA's discretion, the certification timeline may include policy direction and requests intended to further the State's health policy goals.
- (B) Issuers that did not offer a SADP on the Vermont Health Benefit Exchange in the previous year 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 30th two years before the benefit year it wishes to offer a plan. For example, for an Issuer to offer a product beginning January 1, 2018, the letter must be received by November 30, 2016. Such letter must specify whether the Issuer intends to submit certification proposals for 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 process. Non-timely submission may be cause for DVHA to deny plan certification.
- (C) For all Issuers seeking certification, DVHA will offer direction 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 dental plan offerings. Such direction will be communicated to current and prospective Issuers and posted on DVHA's website.
- (D) After its forms and rates are approved by the DFR, a SADP will be transmitted to DVHA for a certification decision.

8202.2.4 Certification Determination of SADPs

- (A) A SADP will be certified under 33 V.S.A. § 1806(A) 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,

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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.”

(B) Subject to DVHA’s termination authority, a SADP will be certified for at least one plan year.

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

(D) DVHA will notify an Issuer of plan certification prior to open enrollment.⁸

(E) In the case of recertification of an existing SADP, DVHA will notify an Issuer of plan recertification at least two weeks prior to open enrollment.⁹

8203 Enrollment

8203.1 Acceptance

(A) Issuers must accept enrollment transactions from the VHBE for qualified individuals following established eligibility determinations as required by federal law. Enrollment transactions must meet technical specifications as provided by DVHA with reasonable advanced notice.

(B) To the extent permissible under federal law, Issuers must conduct direct enrollment of qualified employers and employees under SHOP.

8203.2 System of Record

(A) The VHBE is the system of record for the following relating to qualified individuals enrolled through VHBE:

1. Eligibility of coverage;
2. Effective dates of coverage;
3. Demographic information, including address, birthdate and social security number;
4. Plan selection, including specific metal level, tier and reduced cost sharing level, if applicable; and
5. Premium, including APTC and any VPA.

8203.3 Billing and Enrollment Timeline

Issuers must follow the provisions of the billing and enrollment document outlining enrollment and premium billing requirements in the individual market. The document will be posted on DVHA’s website and will be communicated to Issuers.

8203.4 Termination of Qualified Individuals

(A) Issuers must terminate coverage of qualified individuals for non-payment of premiums after the grace period specified by law.¹⁰

⁸ 45 C.F.R. § 155.1010(a)(1).

⁹ 45 C.F.R. § 155.1075(b).

¹⁰ HBEE §§ 64.06 and 76.00.

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- (B) Issuers must process other terminations of qualified individuals as directed by the VHBE, in accordance with HBEE §76.00.

8203.5 Reconciliation

- (A) Issuers must provide a file to allow the VHBE to reconcile files for qualified individuals for each calendar month. Issuers must provide the file on the fifteenth day of each month, for the previous calendar month. Issuers must provide the following data elements:

- 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 must be secure as provided in the QHP Data Sharing Agreement.¹¹

8203.6 Cost Sharing Accumulators 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 must be transferred from the old QHP to the new QHP for purposes of the calculation of the deductibles and annual limitations on cost sharing. In the event a dependent transfers off a QHP and if the individual was formerly enrolled and remains active, earned cost share shall continue to be credited on the previously issued policy and not on the new policy. For example, if a child moves from an existing family plan and begins a single plan, the single plan shall start with zero cost share and the family plan shall retain the already earned cost share, even if such costs were earned through services provided to the dependent no longer on the policy.

- (B) The provisions in (A) regarding the calculation of deductibles and annual limits on cost sharing 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.

8203.7 Direct Enrollment for the Individual Market

¹¹ 45 C.F.R. § 155.260(b)(2).

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- (A) A QHP Issuer may directly enroll an individual into a QHP pursuant to 33 V.S.A. § 1811(b). This is considered enrollment outside the VHBE and precludes the availability of the federal premium tax credit, VPA, or federal or Vermont cost-sharing reductions.¹²
- (B) The only products available for direct enrollment are QHPs certified under this Rule 8200.
- (C) A QHP Issuer offering direct enrollment outside the VHBE must:
1. Inform applicants that no subsidy is available to direct enrollees and that they may not re-enroll through the VHBE until the next open enrollment period absent a qualifying event;
 2. Provide a link to the VHBE website, including the subsidy calculator, for enrollment in a subsidy-eligible QHP;
 3. Comply with all open enrollment and Special Enrollment Periods and effective dates applicable to the VHBE; and
 4. Credit cost-sharing accumulators in accordance with Rule 8203.7(A) if a customer transitions between the Issuer's QHP through the VHBE and the Issuer's QHP outside the VHBE.

8204 Required Administrative Standards for Issuers8204.1 Technical Requirements

- (A) The Issuer's website will link to the VHBE application website for eligibility determinations.
- (B) With the exception of SADP Issuers, the Issuer's website will link to a subsidy calculator tool located on the VHBE website.

8204.2 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. Issuers may not share medical information of its customers without the consent from the customer.
- (B) VHBE must provide support and information requested by participating Issuers to enable the timely and complete resolution of customer complaints and inquiries relating to issues including coverage status, payment status, and reporting changes to customer information.¹³
- (C) Issuers must make available customer service representatives during normal business hours to assist enrolled consumers with claims related inquiries.
- (D) VHBE must make available customer service representatives during normal business hours to assist enrolled and potential consumers with eligibility, enrollment and payment inquiries.

8204.3 Materials and Marketing

- (A) All enrollee identification cards, with the exception of cards for individuals who have directly enrolled in a QHP outside the VHBE under Rule 8200.3.7(A), must contain the VHBE logo and a toll-free number unique to

¹² This is not considered direct enrollment for purposes of 45 C.F.R. § 156.1230.

¹³ 45 C.F.R. § 155.205 (A).

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enrollees. The card must include the phone number of the VHBE Customer Support line for the Individual Market or SHOP, as applicable.

- (B) Issuers may not alter or substitute the VHBE logo.
- (C) Issuers must provide access to an online provider directory for each plan year and update such provider directory, at their discretion, to assure access to care. VHBE shall provide a link on its website to the applicable provider directory.¹⁴
- (D) Marketing and communications activities by Issuers must comply with federal and state standards concerning those with Limited English Proficiency and the disabled population.
- (E) After submission of materials to the VHBE the following materials may be disseminated after a period of fourteen (14) days, if no objection is made by VHBE:
1. Public communication and correspondence to QHP or SADP 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.
- (F) Review is not required of:
1. Materials containing incidental references to the VHBE programs or activities.
 2. The Issuer's general or promotional materials, including non-VHBE specific advertising, employer or employee newsletters.
 3. Ad hoc communications intended for a specific enrollee or a specific subset of enrollees with a unique situation.
 4. Explanations of benefits or coverage and claims documents.
- (G) Review and notification process
1. The VHBE has the right to disapprove or require changes to materials described in the prior approval requirements of Rule 8204.3, subsection E. 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 disapproval within fourteen (14) days,
 - b. Give reasons for any disapproval or changes required, and
 - c. Notify Issuers if more time is needed to review materials.
 2. In exceptional or emergency circumstances, DVHA may work with Issuers to release materials more quickly than the timeline in subsection (E).
 3. 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.

8204.4 Reporting of Enrollment Data to Vermont Health Benefit Exchange

- (A) For direct enrollment in the individual market, the Issuer must provide a report each month that demonstrates aggregate enrollment data as of the end of the previous calendar month for the number of individuals directly effectuated in a QHP and currently enrolled as of a given plan year, by:
- Overall total;

¹⁴ 45 C.F.R. § 155.205 (b)(1)(viii); 45 C.F.R. § 156.230.

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- Product;
- Metal Level (Platinum/Gold/Silver/Bronze);
- Tier (Single/Couple/Parent & child(ren)/Family);
- Gender (Male/Female);
- Age (<18, 18-25, 26-34, 35-44, 45-54, 55-64, ≥65);
- County (breakout by 14 counties).

(B) For SHOP, the QHP Issuer must provide a report each month containing aggregate enrollment information and any additional data required by the federal government.

(C) Reports must be sent on the fifteenth (15) of the following month (or as federally specified) to the email address: 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.

8204.5 Premium Processing

(A) In the Individual Market, the VHBE collects premiums for a QHP or SADP 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 the Issuer for a QHP or SADP purchased through the VHBE, the Issuer must forward such payment to the VHBE.

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

(D) For direct enrollment, the Issuer collects 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 will approve such policies, and the VHBE and Issuers will post such policies on their websites.

(F) The Issuer is responsible for any collections of outstanding premiums for an enrollee who has been terminated from VHBE coverage.

8204.6 Appeals

If an appeal is filed by an enrollee to the VHBE, the Issuer must cooperate and provide documents and witnesses as is reasonably necessary to adjudicate the appeal or enforcement of an HSB order.

8205 Termination, Non-Renewal or De-Certification of Qualified Health Plan or Stand-Alone Dental Plan¹⁵

8205.1 DVHA Assessment for Continued Compliance

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

¹⁵ 45 C.F.R. § 155.1080.

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8205.2 Process for Appeal of an Action

- (A) The termination, non-renewal, or decertification of a QHP or SADP is 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 or SADP 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, but reasonably in advance of a hearing to enable the Issuer to respond and defend the action.
- (E) Prior to taking an “action,” the VHBE may issue a notice of non-compliance or compliance inquiry to the Issuer. A notice of non-compliance or compliance inquiry will contain:
1. A description 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, if necessary
 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) Upon receipt of a notice of compliance or compliance inquiry, an Issuer shall have the opportunity to provide a written response to the Commissioner, explaining why the Issuer is in compliance or how the Issuer shall come into compliance. Such response shall be filed within 30 days of receipt, unless an extension is granted by the Commissioner. Within 30 days of receipt of such written communication, the Commissioner shall respond in writing and indicate whether he or she agrees with the Issuer’s response, including any corrective action plan, or not.
- (H) Nothing in this rule prohibits the parties from informally resolving an “action,” a notice of non-compliance or compliance inquiry prior to a hearing or formal decision.
- (I) Issuers may appeal an “action.”
1. In order to initiate an appeal, the Issuer must file a letter received by the Commissioner of DVHA within thirty (30) days of receipt of notice of the “action.” The letter must 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 is considered a “contested case” under 3 V.S.A. § 809.
 3. After receipt of the appeal, DVHA will appoint a hearing examiner.
 4. The hearing examiner will manage the case, conduct the hearing and make recommendations to the Commissioner.
- (J) The Issuer shall have a right to appeal the Commissioner’s decision to Superior Court.

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8206 Issuer Withdraw of Qualified Health Plan or Stand-Alone Dental Plan¹⁶

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

8207 Compliance with Other Laws

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 or the Medicaid Act.

8208 Qualified Health Plan Stakeholder Workgroup

DVHA shall convene a QHP stakeholder group during the annual plan design timeline.

¹⁶ 45 C.F.R. § 156.290.