

## Standards for Issuers Participating in the Vermont Health Benefit Exchange Rule

### Responsiveness Summary and Summary of Changes

#### General Comments

Regulations should replace contracts and guidance documents and contain sufficient detail.

**DVHA appreciates all comments and has incorporated comments to provide greater detail in certain areas. In other areas, DVHA would like to maintain flexibility to allow for the best process going forward. DVHA is confident that the stakeholder group will engage to create further detailed criteria going forward.**

Guidance documents referenced in rules must be accessible to the public.

**DVHA agrees with this comment and has clarified that guidance documents will be accessible to the public.**

The rule is more expansive than authority or standards and should be presented accordingly.

**The rule addresses the QHP certification process and decertification process which is based on QHP standards. As a result, DVHA does not see it as more expansive than standards.**

#### 8201—Definitions

Federal Tax Information: Federal Tax Information should not be included because health plans do not obtain federal tax information.

**We agree that health plans do not regularly obtain federal tax information; however, due to the advance payment of the premium tax credit (APTC), it is possible that individuals may provide tax information to plans, in which case, health plans must comply with federal requirements.**

Personally Identifiable Information: The words “personal or identifying” that are underlined above should be removed. These words appear to be redundant, and they have the potential to overly restrict what information is considered PII. For example, in a state the size of Vermont, a person’s diagnosis plus their county could be sufficient to identify an individual. It does not matter whether specifying a county qualifies as “personal or identifying” information if it is “linkable to a specific individual.”

**We agree and made the suggested change.**

Tier—Include requirement that health plans offer QHPs at four tier options: single, two-person, adult and child(ren), and family.

**Vermont will continue to require that health plans offer QHP at four tier options: single, two-person, adult and child(ren), and family. We have clarified this requirement in 8202.1.2(J) section of the rule.**

Vermont Premium Reduction (or VPA)—Use one term or the other, but not both, preferably Vermont Premium Assistance.

**While the Vermont premium subsidy is commonly known as Vermont Premium Assistance or VPA within the state, premium assistance has an entirely different meaning at the federal level. Accordingly, the Vermont premium subsidy is called the Vermont Premium Reduction in our rules, but we acknowledge that it is often called Vermont Premium Assistance.**

Termination, non-renewal, or decertification—these terms should be separately defined.

**We have refined these terms. Decertification means termination of a QHP or denial of certification for a subsequent, consecutive certification cycle. Non-renewal pertains to issuer non-renewal, as discussed at 45 C.F.R. § 156.290.**

“Plan” should be defined-- Does the term include all products at each metal level or only one plan at a specific metal level? As we previously communicated, we suggest using the federal terms. Federally, the product is the benefit design and the plan is the metal level. For example, Blue Rewards is the product, Blue Rewards Silver is the plan.

**The term “plan” has been clarified as meaning a QHP or SADP.**

### **8202—Vermont Health Benefit Exchange Certification**

This section should reference the rate review process so that health plans which are not currently participating in the exchange are aware of their obligations regarding rate review. Additionally, the current rate review process is not well documented in one place. This rule seems a logical place to capture those requirements.

**We agree that health plans should be aware of their obligations regarding rate review. We will refer to the rate review statute where applicable.**

The rule should distinguish between standards that are applicable to health plans as entities and standards that are applicable to qualified health plans as products. For example, numerous items are included in this section that are applicable to the product offerings, not to the entity that offers the products. These include Section 8202.1.1(F) dictating that non-Standard plans must be offered at certain metal levels and Section 8202.1.1(G) requiring a child-only QHP offering.

**The standards at 8202.1.1 are related to the entity that offers the products. If the Issuer does not offer QHPs meeting the requirements listed in 8202.1.1, then none of their QHP offerings shall be certified.**

8202.1.1(B) This rule provides a new issuer that is not accredited "must receive accreditation within a reasonable timeframe as determined" by VHC. However, 45 C.F.R. § 155.1040 provides that an Exchange "must establish a uniform period of time following certification" that an issuer shall become accredited. We do not believe the discretionary standard is consistent with VHC's obligation pursuant to federal law. Furthermore, it's unfair to the health plans that are investing in the cost of maintaining a current accreditation to allow new market entrants a possibly unlimited period of time to undertake such efforts. A specific timeline should be identified in the rule. At a minimum, DVHA could define a set period of time, but allow for an exception request process.

**In order to be consistent with the Department of Financial Regulation's (DFR's) oversight, the rule will reference 18 V.S.A. § 9414(b)(4), which requires that a managed care organization be accredited by a national independent accreditation organization approved by the Commissioner.**

8202.1.1(E) This section mandates that a health plan must offer all standard plans at each metal level. It might be good to clarify that this includes all cost share reduction plans, and further note that those plans will be unique to Vermont due to the existence of the Vermont cost share reduction program.

**We agree and have made the suggested changes.**

8202.1.1(F) This section mandates that a health plan offer non-standard plans. However, it is our understanding of current policy that DVHA does not mandate that health plans offer non-standard plans.

**We agree. DVHA does not mandate that health plans offer non-standard plans. We have made the suggested changes.**

8202.1.1(H) Currently, DVHA only permits standard and non-standard plans. What types of additional plans does DVHA intend to authorize by this language?

**We would like to provide flexibility for DVHA to suggest new Non-Standard QHPs as was done with the gold high deductible QHP.**

8202.1.2 Standards for Qualified Health Plan Designs

The nondiscrimination standards under Section 1557 of the ACA should be included in this list of standards. The requirements for coverage of preventive services under 45 C.F.R. § 147.130 should also be included in this list of standards.

**These federal standards will apply, as acknowledged at section 8209.**

8202.1.2(A)-(D) The Department of Financial Regulation (DFR) makes determinations around appropriate EHB, coverage levels, actuarial value, and network adequacy. We request that the rule make it clear that DFR is responsible for these determinations. For example, 8202.1.2(A) could read "provide an EHB package, as determined by DFR."

**We agree and have made the requested changes. It should be noted that the Green Mountain Care Board determines the appropriate EHB package.**

8202.1.2(G) This section requires that qualified health plans meet "QHP Issuer rate and benefit information requirement [sic] of 45 C.F.R. § 155.1020." There are several problems with this section. First, 45 C.F.R. § 155.1020 standards include three distinct parts, all of which pertain to VHC, not qualified health plan products: 1) the exchange must ensure that it receives justifications for rate increases; 2) the exchange must consider specific factors when considering a rate increase; and 3) the exchange must receive information pertaining to rates, covered benefits and cost-sharing at least once per year.

However, in order for VHC to comply with the requirements of 45 C.F.R. § 155.1020, it must require certain actions by health plans. As these standards are applicable to issuers (as opposed to plan designs), we recommend moving them into Section 8202.1.1 (standards applicable to issuers) above. his

rule would be an excellent place to document how our current system works. For example, GMCB reviews rates. This should be specified here. Rate justifications are provided and analyzed by GMCB. This rule could indicate that to meet its obligations pursuant to 45 C.F.R. § 155.1020(a) and (b), VHC will defer to the GMCB. This accomplishes two objectives: 1) it brings VHC into explicit compliance with its federal obligations; and 2) it provides clarity to the public and health plans about how the Vermont rate review system works.

**We have moved this section to issuer standards for QHP offerings and have referenced the rate review statute where applicable.**

8202.1.2(I) This section mandates the compliance with applicable law pertaining to the privacy and security of federal tax information. Issuers do not obtain federal tax information and we do not want to obtain federal tax information. We do not obtain federal tax information pertaining to our individual members and we have no compliance program associated with such an endeavor. We strongly object to including this language as it creates obligations (and expense) for no identified policy objective.

**We agree with the comment that health plans do not intentionally obtain federal tax information; however, due to the advance payment of the premium tax credit (APTC), it is possible that individuals may provide tax information to plans, in which case, health plans must comply with federal requirements.**

This standard is applicable to qualified health plan products. Plan designs are not related to compliance with privacy and security standards, such compliance occurs through activities of the health plans. This should be moved to Section 8202.1.1, pertaining to health plans.

**We have moved this section to issuer standards for QHP offerings.**

We request all references that inaccurately imply that health plans will collect or protect federal tax information be removed from the rule.

**To the extent that health plans come into contact with federal tax data, they must comply with federal law.**

8202.1.3 It appears this subsection was inadvertently left out of the table of contents.

**This is a subsection of 8202.1, so it is not in the table of contents.**

8202.1.3(B) This section states that new issuers (those who have not previously offered a QHP on VHC), shall specify in letter of intent "whether the Issuer intends to submit certification proposals for Standard and Non-Standard QHPs." As noted above, the rule fails to clarify the minimum allowed product offerings. We suggest rephrasing this sentence to read: "whether the issuer intends to submit certification proposals for Non-Standard QHPs, in addition to the mandatory Standard Plans."

**We agree and have made the requested change.**

This section concludes: "Non-timely submission may be cause for DVHA to deny plan certification." It's not clear what non-timely submission this applies to. This section should specify that non-timely submission of the letter of intent shall be ground for denial.

**We agree and have made the requested change.**

8202.1.4 It appears this subsection was inadvertently left out of the table of contents.

**This is a subsection of 8202.1, so it is not in the table of contents.**

8202.1.4 There is an important functional difference between initial plan certification and re-certification that should be acknowledged in the rule. Denial of re-certification causes greater disruption in the market. DVHA should define standards applicable to DVHA's decision to not re-certify (or renew) an existing product offering. Those standards should balance the impact of the market disruption associated with such a decision with the need for DVHA to achieve its overall policy objectives of creating a better individual insurance market. This approach would also be consistent with federal regulatory framework, where it appears VHC is required to have two separate processes. 45 C.F.R. § 155.1000 requires that Exchanges have a certification process, while 45 C.F.R. § 155.1075 requires that Exchanges have a recertification process that includes a portion of the certification process.

**A denial of recertification will be considered a decertification, which encompasses the same rights and process.**

8202.1.4(A)(5) The phrase “other criteria as DVHA deems appropriate” is vague and needs to be clarified.

**This phrase provides DVHA with the flexibility to ensure that all requirements are met. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

8202.1.4(D) & (E) These sections provide that DVHA will notify plans of certification prior to open enrollment and notify plans of recertification at least two weeks prior to open enrollment. This is operationally unrealistic for plans and will be disruptive to consumers. DVHA should make certification decision and notification plans during the first full week to September or as soon as practicable.

**This timeline provides DVHA with the flexibility to ensure that all requirements are met. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

### **8203—Enrollment**

In general, enrollment needs to be accurate, and VHC must leave patients, providers, and issuers harmless when there are inaccuracies.

**DVHA strives for accurate enrollment. We believe all inaccuracies will be determined and corrected through monthly reconciliation going forward. DVHA is open to discussing this issue further with the stakeholder group outlined at section 8209.**

#### 8203.1 Acceptance

8203.1(A) VHC should be required to provide transactions in the standard EDI format, as required by federal law.

**DVHA agrees with this requirement and has added this requirement to this rule, along with the requirement that Issuers do the same.**

8203.1(A) This language requires health plans to comply with DVHA technical specifications provided there is reasonable notice. The plans cannot comply with the specifications unless the documentation provided by DVHA is accurate. We suggest adding “provided such documentation is complete” at the end of the second sentence in this section.

**The implication in this language is that the documentation provided by DVHA will be complete. We find adding “provided such documentation is complete” to be redundant.**

In paragraph (B), the rule should specify how the Small Employer Health Benefits Program Rules (HBEE Part Six) apply to direct small business enrollments. Under these proposed rules, all small business health plan enrollments in Vermont are SHOP enrollments. Federal and state SHOP rules include provisions on enrollment, effective dates, terminations, notice to employers and employees, and appeal rights. Not every rule in HBEE Part Six would make sense in the direct enrollment context, so these rules should clarify which rules do apply, and how they are to be implemented by issuers. The SHOP rules may need to be re-written to make sense for direct enrollments.

**We agree that the SHOP rules will need to be revisited in the HBEE, but that those changes do not apply to this rule.**

#### 8203.2 System of Record

This rule should obligate VHC to maintain accurate and timely enrollment records. If DVHA refuses to accept responsibility for its enrollment records, Vermonters are at risk of having no recourse when there is a problem with the VHC system or having DVHA apply inconsistent rules. The 2014, 2015, and 2016 plan years have been subject to a contract between VHC and the health plans. That contract held health plans, and those that pay premiums, harmless for VHC errors in enrollment processing. This rule should do the same.

**DVHA strives to maintain accurate and timely enrollment records. We believe all inaccuracies will be determined and corrected through monthly reconciliation going forward. DVHA is open to discussing this issue further with the stakeholder group outlined at section 8209.**

#### 8203.3 Billing and Enrollment Timeline

The proposed regulation refers to requirements that will be outlined in a document posted on the DVHA website. We do not see such a document posted on DVHA’s rules website, but there is a Billing and Enrollment Timeline from November 2015 posted on VHC’s website, on the legal guidance page. It appears this rule should refer to that website rather than the DVHA website. Alternately, a link to the VHC legal guidance page could be added to the DVHA website’s rules page.

**DVHA agrees with this comment and will post the guidance on its website.**

We appreciate DVHA’s efforts to convene stakeholders to discuss billing and enrollment issues and give input on revising the 2015 billing and enrollment document. When that document has been revised, the details should be incorporated into these rules.

In the absence of formal rulemaking, and given the problems with billing and enrollment over the past two years, the rules should contain a process for developing any non-regulatory requirements that would be binding on issuers. We suggest the following language: DVHA may issue documents including technical enrollment, billing or premium collection guidance. Any such document shall be posted on the DVHA website and distributed to all interested parties, including the Medicaid and Exchange Advisory Board, issuers and the Vermont Office of the Health Care Advocate, at least 45 days prior to the intended effective date. DVHA shall accept public comment on the guidance and provide a reasonable deadline for such comment.

**The current rules provide DVHA with the flexibility to address billing and enrollment issues. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

This rule fails to provide a meaningful billing and enrollment regulatory framework.

**The current rules provide DVHA with the flexibility to address billing and enrollment issues. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

We strongly object to continuing with an approach that doesn't obligate DVHA to formally agree to billing and payment timelines. Not only would this benefit health plans, but consumers have a right to rely on binding billing rules that clearly detail their rights and obligations. Merely publishing them on the website does not allow for any public process to object to such timelines if they are unfair or operationally unworkable.

**The current rules provide DVHA with the flexibility to address billing and enrollment issues. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

We suggest that the billing timelines included in the rule describe the timelines that have been in place since 2014: customers are billed on the 5th of the month for the following month, bills state the payment is due on the 26th of the month, bills postmarked by the last day of the month will be treated as timely. If these timelines are not included in the rule, can you please explain why it is better to have the billing rules informal?

**The current proposed rules provide DVHA with the flexibility to address billing and enrollment issues. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

The rule should clearly state that VHC customer bills must be accurate and that any failure to do so will be the obligation of VHC to correct, not the obligation of the customer, health plan, or providers.

**DVHA strives for accurate billing. We believe all inaccuracies will be determined and corrected through monthly reconciliation going forward. DVHA is open to discussing this issue further with the stakeholder group outlined at section 8209.**

The rule should specify that VHC will accurately and timely apply premium payments to the correct customer account.

**DVHA strives for accurate and timely premium payments. DVHA is open to discussing this issue further with the stakeholder group outlined at section 8209.**

Consumers should be held harmless when DVHA does not timely pay subsidies.

**DVHA strives to maintain accurate and timely payment of subsidies. DVHA is open to discussing this issue further with the stakeholder group outlined at section 8209.**

The rule should obligate VHC to timely transmit premiums collected from consumers to health plans.

**DVHA strives to timely transmit premiums. DVHA is open to discussing this issue further with the stakeholder group outlined at section 8209.**

The rule should obligate VHC to maintain accurate enrollment records to ensure that bills are premiums collected and accurate.

**DVHA strives to maintain accurate and timely enrollment records. We believe all inaccuracies will be determined and corrected through monthly reconciliation going forward. DVHA is open to discussing this issue further with the stakeholder group outlined at section 8209.**

The rule should place reasonable limitations on VHC's ability to change records retroactively when there is no Human Services Board ruling mandating the change because retroactive changes create incredible disruption. We respectfully request that the rule specify under what conditions VHC can make a post-90 day retroactive change and state that when VHC makes such a decision, it will assume responsibility for that decision.

**As of January 1, 2017, DVHA will pay premiums for a termination or cancellation to an issuer with an effective date of more than 6 months in the past. See section 8203.4 for more details.**

This rule should obligate VHC to reimburse health plans for claims incorrectly paid when such claims were paid due to VHC error. In the past, pursuant to contract, VHC has assumed responsibility for the claims paid that should not have been paid (unless such claims should have been paid by Medicaid, in which case the claim is recouped by the health plan and paid by Medicaid). We strongly object to VHC refusing to continue to assume this responsibility by not incorporating these important contract provisions into the rule. We ask that VHC assume responsibility for the cost of claims paid for coverage that VHC negligently maintained as active.

**DVHA strives to maintain accurate and timely enrollment records. We believe all inaccuracies will be determined and corrected through monthly reconciliation going forward. As of January 1, 2017, DVHA will pay premiums for a termination or cancellation to an issuer with an effective date of more than 6 months in the past. See section 8203.4 for more details.**

Currently, VHC holds premiums if they do not match the billing. VHC should apply premium collected from an enrollee to that enrollee's account for any period in which coverage is active and such amounts should be remitted to health plans, regardless of whether they match the bill exactly.

**The current rules provide DVHA with the flexibility to address billing and enrollment issues. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

VHC refunds the entire amount of premium collected for coverage that is ultimately canceled, even for a period when there are claims. VHC should forward partial payments that are related to periods of active coverage.

**The current rules provide DVHA with the flexibility to address billing and enrollment issues. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

The rule should implement a partial payment tolerance to allow members' accounts to be treated as current when bills are paid almost in full. We suggest that payments that are within \$10 of the total amount due be treated as payment in full, with the balance being billed the next month.

**The current rules provide DVHA with the flexibility to address billing and enrollment issues. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

VHC should refund collected premiums for canceled coverage within 15 business days.

**The current rules provide DVHA with the flexibility to address billing and enrollment issues. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

#### 8203.4 Termination of Qualified Individuals

The rule should obligate VHC to timely and accurately process enrollment terminations. For example, if an individual is found eligible for Medicaid, VHC is responsible for initiating the termination of the QHP and enrolling the individual in Medicaid in a timely fashion.

**DVHA strives to maintain accurate and timely terminations. We believe all inaccuracies will be determined and corrected through monthly reconciliation going forward. As of January 1, 2017, DVHA will pay premiums for a termination or cancellation to an issuer with an effective date of more than 6 months in the past. See section 8203.4 for more details.**

8203.4(A) This rule says issuers “must” terminate coverage for nonpayment after the grace period. There have been many cases where payment records from VHC are not accurate or where nonpayment was due to technical issues with VHC and was not the fault of the individual. The rule should provide flexibility to appropriately handle nonpayment due to VHC error or plan error.

**DVHA strives to maintain accurate billing records. We believe all inaccuracies will be determined and corrected through monthly reconciliation going forward. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

8203.4(A) There should also be flexibility for plans to authorize termination of coverage in situations besides nonpayment in order to better facilitate payment of claims, for example.

**DVHA is open to exploring this issue. Stakeholders may use the stakeholder workgroup at section 8209 to address this issue further.**

8203.4(A) Termination for nonpayment rules should contain grace period detail. The rules are well-defined for individuals receiving the advance payment of the premium tax credit (APTC), Vermont statutes are unclear on how the grace period applies to unsubsidized participants. We suggest allowing a nonsubsidized individual to have a one-month grace period where claims will pay during that period,

but that the coverage will end after the first month unless the individual makes full payment. We also suggest limiting reinstatement by full payment to twice in a plan year.

**Federal regulations have the QHP issuer establishing a standard policy for the termination of enrollment of enrollees through the Exchange due to non-payment of premium at 45 C.F.R. § 156.270(c). This is a QHP issuer requirement, not VHC requirement.**

#### 8203.5 Reconciliation

The rule should reflect that VHC's reconciliation process is still a work in progress. Rather than requiring health plans to provide 18 specific data elements each month, we suggest drafting this section of the rule with greater flexibility, focusing on the intended purpose of a reconciliation process, as opposed to specifying the operational details of the process. We also would like to see a commitment, in the rule, to reconciling payments (received and due) in addition to the current data elements that are being reconciled.

**After performing reconciliations for the past two years, DVHA has determined that the data elements listed in the rule are essential to the process.**

#### 8203.6 Cost Sharing Accumulators for Transferring Enrollees, Including Direct Enrollees

Paragraph (B) limits the transfer of cost sharing to those individuals who enroll in a new plan with the same metal level where paragraph (A) does not include that limitation. We believe that both paragraphs should allow cost sharing to transfer when an individual changes metal levels but remains with the same QHP issuer. Blue Cross Blue Shield of Vermont has agreed to this change and has stated that this currently occurs in practice.

The small potential for a few policyholders to abuse the system does not outweigh the harm to individuals who have in good conscience paid their cost sharing and then must change plans including metal levels. We have asked the insurers if they have any evidence that the rule change would cause a significant financial burden to insurers and they have not provided any such evidence. At the very least, paragraph (B) should allow individuals to transfer their cost sharing if they move to a plan with the same or a lower metal level offered by the same issuer. This would eliminate the opportunity to abuse the system.

We have been told that this rule will not change due to a previous agreement from 2014 between DVHA and the insurers. We have asked for a copy of the agreement but have not yet received it. To the best of our knowledge, this agreement did not incorporate feedback from any consumer advocates. We ask that DVHA consider this feedback now.

**As a result of this comment, DVHA has reevaluated this issue further and determined that it is fair and equitable for cost accumulators should transfer across markets in the same way they do with an SEP. DVHA will work with issuers to ensure that this happens and has made the subsequent change in the rule.**

#### 8203.7 Direct Enrollment for the Individual Market

DVHA does not have jurisdiction over the individual insurance market outside of the Vermont Health Benefit Exchange. The correct regulatory body is the Department of Financial Regulation.

**Under 18 V.S.A. § 1811, plans in the small group and individual market are considered health benefit plans and are administered through VHC.**

Direct enrollment raises questions about how the State will ensure that rules applicable to both VHC and direct enrollments are uniformly interpreted and applied. We anticipate issues are likely to arise mainly in the SEP context. Qualified individuals should be able to transfer their application to the VHC if they believe their direct enrollment application was wrongly denied under VHC criteria. This would ensure uniform application of the SEP rules. We request that this basis for an SEP be added to the HBEE rules.

**DVHA will consider these issues in the context of the HBEE rule.**

8203.7(c)(4) We believe the cross-reference here is intended to be 8203.6(A).

**We agree and have made the requested change.**

### **8204—Technical Requirements**

#### 8204.1 Technical Requirements

8204.1(A) This provision is confusing, because it could be read to say that VHC must conduct eligibility determinations. This could be clarified by requiring the issuer's website to link to the VHC application at the URL provided by VHC.

**We agree and have made the requested change.**

#### 8204.3 Materials and Marketing

8204.3 (D) Issuers must comply with federal and state standards concerning those with Limited English Proficiency and the disabled population. There are federal requirement on insurer materials for individuals with Limited English Proficiency that apply to QHPs being sold on Exchanges. We ask that these rules affirmatively state in paragraph (D): "All such federal and state standards for QHPs sold in Exchanges shall apply to QHPs purchased in Vermont directly from insurers." Insurers will be creating materials to comply with these rules for their QHP plans sold on the VHC, so this clarification would not increase the burden on insurers. It also would prevent confusion to additionally require these materials to be in plain language at no higher than an eighth grade reading level.

**Under 18 V.S.A. § 1811, plans in the small group and individual market are considered health benefit plans and are administered through VHC. As a result, these standards will apply to such plans.**

8204.3(D) Can you explain why this rule does not obligate VHC to meet federal and state standards concerning those with limited English proficiency and the disabled population?

**Vermont Health Connect is obligated to meet federal and state standards concerning those with limited English proficiency and the disabled population. That requirement is not included here because this rule addresses standards for issuers participating in the Vermont Health Benefit Exchange.**

8204.3(G)(1) VHC should not make material review periods longer than those negotiated in contract. The proposed rule extends the current timeline that VHC will notify a health plan regarding a problem with marketing material from 7 days to 14 days. Also, the rule allows VHC 14 days to notify health plans

that more time is needed to review materials. We request that VHC provide reasonable limitations around the extra time it can take to review materials and specify the circumstances under which it can impose a delay. We would prefer to see that VHC can only ask for extra time in extraordinary circumstances.

**We have reevaluated the notification timeline and have changed the notification period from 14 days to seven days as suggested. The rest of the section will remain unchanged.**

8204.3(G)(3) This section mandates that health plans provide a copy of the final approved materials one business day before the material is disseminated. For some communications, it's impossible to produce a "final" version prior to the date the materials are distributed to the public because the vendor that is producing the final version is also mailing them out, typically in the same job. We respectfully request that the rule be modified to allow the submission of the final version the day before production, if possible, or the day disseminated if it is not practicable to provide the day before. The rule as currently drafted could be a very expensive requirement and it's not clear the mandate serves any policy objective.

**DVHA must see the materials in advance, and one day strikes a balance between DVHA needing to see the materials and the materials being disseminated. Nothing prohibits the issuers from providing the materials the day before production.**

8204.4 Reporting of Enrollment Data to VHC

We do not believe that DVHA has jurisdiction over the individual insurance market, to the extent that such insurance is not considered on the exchange (as this is not). We believe DFR has this jurisdiction.

**Under 18 V.S.A. § 1811, plans in the small group and individual market are considered health benefit plans and are administered through VHC.**

8204.5 Premium Processing

This rule should obligate VHC to perform premium processing functions accurately and timely.

**That requirement is not included here because this rule addresses standards for issuers participating in the Vermont Health Benefit Exchange.**

The VHC is subject to regulations regarding termination of coverage for failure to pay premiums. It is not clear whether this rule is intended to refer to those regulations or to additional policies that may be developed to supplement the regulations. Paragraph (C) should incorporate sections 64.06 and 76.00 of the HBEE rule, and should also reference section 8203.4 of this rule, regarding termination of qualified individuals. If DVHA intends to establish different termination policies for direct enrollment QHPs, that should be explicitly stated and those policies should be incorporated into this rule once they are developed. We think it would be preferable to have the same termination policies for all QHPs.

**The requirement is not included here because this rule addresses standards for issuers participating in the Vermont Health Benefit Exchange.**

8204.5(E) Paragraph (E) on SHOP termination policies should incorporate section 43.00 of the HBEE rule. If DVHA intends to establish different termination policies for direct enrollment SHOP plans, that limitation should be explicitly stated in the rule. Those policies should be incorporated into this rule once they are developed. We think it would be preferable to have the same termination policies for all QHPs.

**Federal regulations have the QHP issuer establishing a standard policy for the termination of enrollment of enrollees through the Exchange due to non-payment of premium at 45 C.F.R. § 156.270(c).**

8204.5(E) We object to this rule's new obligation to require health plans to submit group termination policies to VHC for approval. At the very least, VHC should articulate a standard of review.

8204.5(E) This rule should include language that captures some of the informal agreements that are currently in place between the health plans and VHC about reinstating groups that fail to pay their premiums outside the open enrollment period.

**That requirement is not included here because this rule addresses standards for issuers participating in the Vermont Health Benefit Exchange.**

8204.5(E) References to "SHOP" should be removed because there is no actual SHOP.

**We agree and have incorporated this suggestion into the rule.**

#### 8204.6 Appeals

An appeal process should be required for eligibility denials and terminations relating to direct enrollments. We understand that health insurance issuers will refer consumer complaints regarding adverse enrollment or termination decisions to the Department of Financial Regulation (DFR) if a consumer is not satisfied with the issuer's internal review process. This rule should codify that practice if DFR agrees to accept complaints on those issues, or otherwise clarify direct enrollees' appeal rights.

**DVHA will consider these issues in the context of the HBEE rule.**

#### **8205—Termination, Non-Renewal or Decertification of a QHP**

This rule needs an explanation of the difference between "termination" and "decertification."

**We agree. Federal law incorporates termination within the definition of decertification.<sup>1</sup> We have updated the definition of decertification accordingly.**

Non-renewal and decertification are functionally different and should have different processes. For instance, with non-renewal, customers are entitled to 90 days' notice from health plans, so they can prepare for the next open enrollment.

---

<sup>1</sup> See 45 C.F.R. § 155.430(b)(2)(B)(iv).

**We have clarified the definition of nonrenewal at 8201.**

DVHA does not provide enough due process for either termination, non-renewal, or decertification. We suggest an alternative process that allowed DVHA to immediately decertify a QHP in an emergency, but provided reasonable notice and a process to work through health plan objections and cure any established non-compliance in the absence of an emergency. The enforcement process applicable to the FFM would be a good model for this rule to follow.

**DVHA is providing the due process of a contested case under 3 V.S.A. § 809. This process is well-tested through other agencies.**

The enforcement process doesn't appear to comply with federal requirements under 45 C.F.R. § 155.1080(e) for decertification.

**We have incorporated the relevant notice requirements under 45 C.F.R. § 155.1080(e) into the rule.**

8205.2 Process for Appeal of an Action

This section refers to a broader enforcement framework than appealing an "action," and the title should reflect this.

**We have changed this section to apply to decertification.**

8205.2(B) The rule should contain specific materiality standards by which VHC will consider decertification or non-renewal as an appropriate compliance action.

**The appropriate standards are within the rule as well as state and federal law.**

8205.2(C) VHC should not be able to take an "action" without notice, absent an emergency. We suggest an action should not be effective less than 90 days in the future, absent a finding of immediate threat to public safety. The rule should also specify details regarding a hearing.

**We agree and have incorporated a notice requirement into the rule.**

Section 8205.2(E) - VHC should not be allowed to issue a notice of non-compliance without any process.

**This notice of non-compliance was based from federal regulation 45 C.F.R. §156.806, which does not have a process. The notice of non-compliance is a tool to allow issuers to comply with the relevant standards prior to a formal decertification.**

Section 8205.2(F) - Notices of non-compliance and corrective actions must be appealable.

**This notice of non-compliance was based from federal regulation 45 C.F.R. §156.806, which does not have a right to appeal. The notice of non-compliance is a tool to allow issuers to comply with the relevant standards prior to a formal decertification.**

**8209—Qualified Health Plan Stakeholder Workgroup**

The stakeholder workgroup should meet for a minimum number of times, have a minimum defined membership and be required to consider certain topics.

**DVHA would like to maintain flexibility around the stakeholder workgroup so that they may address issues as needed.**