

VERMONT
QUALIFIED HEALTH PLAN &
QUALIFIED DENTAL PLAN
GUIDANCE FOR PARTICIPATION

UPDATED SEPTEMBER 2023
FOR THE 2024 PLAN YEAR

Contents

Section 1	Introduction.....	5
1.1	Glossary.....	5
1.2	Certification Process and Timeline	7
1.2.1	Letter of Intent for first year of participation.....	7
1.2.2	Initial Plan Design	8
1.2.3	Certification of QHPs and QDPs.....	8
1.2.4	Term of Engagement	9
1.2.5	Notification for Changes in Plan offerings.....	9
1.2.6	Participation Agreement, Trading Partner Agreement (TPA), and Electronic Data Interchange (EDI) Testing.....	9
1.3	Applicability and Changes.....	9
1.4	Vermont Contact Information.....	10
Section 2	QHP Certification Standards.....	11
2.1	QHP Issuer Licensure.....	11
2.2	Required Enrollment Categories	11
2.3	Service Area	11
2.4	Benefit Design Standards.....	11
2.4.1	Required Metal Tiers for Standard Plan Designs	12
2.4.2	Approval of Standard Plans	12
2.4.3	Requirements Related to Non-Standard Plans.....	12
2.4.4	Individual Plan Availability for Individuals Less than 21 Years Old	13
2.4.5	Plan Accumulators.....	13
2.4.6	Vermont Cost Sharing Reduction (VCSR)	13
2.5	Review of Summary of Benefits and Coverage (SBC) and Plan Documents.....	13
2.6	Compliance with Non-Discrimination Laws.....	14
2.7	Accreditation.....	14
2.8	Marketing Materials.....	15
2.8.1	Review of Materials.....	15
2.8.2	Review Process.....	15
2.8.3	Identification Cards.....	15
2.8.4	Issuer and Exchange Logos.....	16
2.9	Network Adequacy	16

2.10	Provider Directory.....	16
2.11	Formulary.....	16
2.12	Quality Requirements	17
2.12.1	Quality Improvement Strategy (QIS).....	17
2.12.1	Quality Rating System (QRS).....	17
2.13	Attestation.....	17
2.14	Enrollment Process Overview	17
2.14.1	Individual Market Enrollment.....	18
2.14.2	Acceptance of enrollment and provision of benefits to Qualified Individuals	18
2.15	Posting Justifications for Premium Changes.....	18
2.16	Information reported in SERFF.....	19
2.17	Other Reporting.....	19
2.18	Notices and Forms	19
2.19	Customer Complaints & Appeals.....	19
2.20	Audits	20
2.21	Premium Processing.....	20
2.22	Customer Service.....	20
2.23	Risk Stabilization Program	20
2.24	Small Business Health Options Program (SHOP).....	21
Section 3	Qualified Dental Plan (QDP) Certification Standards	21
3.1	Certification Standards Applicable to QDPs.....	21
3.2	QDP Enrollment Process Overview.....	22
3.2.1	Required Enrollment Categories.....	22
3.2.2	Individual Dental Plan Availability for Individuals Less than 21 Years Old.....	22
3.3	QDP Benefit Design.....	22
3.4	Posting Justifications for Premium Changes.....	23
Section 4	Compliance Monitoring and Decertification	23
4.1	Compliance Monitoring.....	23
4.1.1	Initiation	23
4.1.2	Issuer Response.....	24
4.1.3	Compliance Inquiry Conclusion.....	24
4.2	Decertification.....	24
4.2.1	Process	24

4.2.2	Appeal	24
4.2.3	Notice.....	25
Section 5	Recertification and Renewal of Issuer Participation	25
5.1	Recertification	25
5.2	Recalculation of plan cost sharing amounts following federal revision of AV requirements	25
5.3	Rate changes and justification	26
5.4	Auto-renewal of existing enrollees.....	26
5.5	Decision not to seek recertification.....	26
5.6	Denial of Recertification	26
5.7	Market exit.....	26
Section 6	Obligations with respect to enrollees upon non-renewal, non-recertification, decertification, and market exit	27
6.1	Notification Deadline	27
6.2	Contents of notification.....	27
6.3	Continuing Coverage After Decertification.....	27
APPENDIX A:	Critical Certification Steps for Issuers	28

Section 1 Introduction

The Department of Vermont Health Access (DVHA) administers the Vermont Health Connect (Exchange), Vermont's Health Benefit Exchange. Customers use the Exchange to evaluate, compare, and enroll in Qualified Health Plans (QHPs) and/or Qualified Dental Plans (QDPs) offered by Issuers.

To offer QHPs or QDPs on the Exchange or to offer Reflective Plans, Issuers must follow requirements established in the annual QHP certification timeline including the final step of formal certification by the DVHA Commissioner. This Guidance provides information about the procedures and criteria used by DVHA when evaluating, certifying, recertifying, and decertifying plans and when investigating and remediating compliance issues.

All individual and Small Group health plans, including reflective plans, offered in the State of Vermont must be certified by DVHA for Vermont's individual and Small Group markets. Plans sold directly through Issuers including the Reflective Plans are considered off-exchange but are identical to QHPs offered through the Exchange. Individual and Small Group health plans provide the same benefits and cost sharing amounts, irrespective of market; however, premium rates are filed separately for the individual and Small Group markets and undergo separate approval from the Green Mountain Care Board.

Stand-alone dental plans (SADPs) may be certified and offered on the Exchange as QDPs or off-exchange by dental Issuers. SADP Issuers are not required to participate on the Exchange if they only wish to offer SADPs off-exchange. SADP Issuers may choose to offer plans on the individual market, on the Small Group market, or on both markets. SADPs offered on the Exchange must be certified by DVHA. This Guidance addresses requirements and certification criteria of SADPs that will be offered on the Exchange as QDPs.

Along with DVHA, the Department of Financial Regulation (DFR), and the Green Mountain Care Board (GMCB) have distinct and interdependent regulatory roles throughout the annual certification process and require the careful and coordinated participation by the Issuers. The table in Section 1.2.3 below provides further detail regarding responsibility for specific elements of the annual QHP certification cycle, shared among DVHA, DFR, and GMCB. This guidance contains references to DFR and GMCB where appropriate, but it does not supersede their authority.

The requirements contained in this Guidance apply to an Issuer and all its subsidiaries, if any. An Issuer and its subsidiaries will be considered one entity for QHP submission purposes.

1.1 Glossary

Accumulators refers to out of pocket expenses contributing toward the plan's overall deductible and maximum out of pocket amounts paid by a QHP customer for health services in the coverage year.

Advanced Premium Tax Credit (APTC) means the advanced tax credit created by the federal Patient Protection and Affordable Care Act (ACA), which takes the form of a premium subsidy for eligible

individuals who purchase a QHP through the Exchange. The APTC shall be paid directly to issuers from the United State government on behalf of an eligible individual to reduce the Individual’s premiums.

Affordable Care Act (ACA) means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), pertaining to the federal mandate to render health insurance coverage widely available to the public.

Annual Open Enrollment Period (AOEP) means the time designated for individuals and small businesses to enroll in or make changes to their medical and/or dental coverage, generally November 1 – January 15. See [HBEE Part 7](#) 71.02(e).

DFR means the Vermont Department of Financial Regulation.

DVHA means the Department of Vermont Health Access.

Employee shall have the meaning of “qualified employee” set forth in 45 C.F.R. § 155.20.

Enrolled means the point at which an individual is covered for benefits, that is, when coverage becomes effective, under an individual or group QHP, reflective plan, or QDP, without regard to when the individual may have completed or filed any forms that are required to become covered under a plan.

Enrollee means an individual or an Employee, and their dependent(s), enrolled in a QHP, reflective plan, or QDP.

Essential Health Benefits (EHB) shall have the same meaning as 42 U.S.C. § 18022(b) and implementing regulations.

GMCB means the Green Mountain Care Board.

HHS means the U.S. Department of Health and Human Services.

Issuer means an insurance company, insurance service, or insurance organization formed to do health insurance as defined in 8 V.S.A. § 3301(a). For purposes of this Guidance, this term shall include Issuer’s subsidiaries engaged in health insurance.

NCQA means the National Committee for Quality Assurance.

Plan Year means the calendar year during which the QHP Issuer provides coverage for health benefits.

Qualified Dental Plan (QDP) means the stand-alone dental plan set forth in the letter of Certification.

Qualified Health Plan (QHP) means the health benefit plan set forth in the letter of Certification.

Reflective Plan means a reflective health benefit plan as defined by 33 V.S.A. § 1813.

SERFF means System for Electronic Rates and Forms Filings.

Service Area means the geographical area in which a QHP or QDP accepts individuals and employers for enrollment.

Small Group shall have the same meaning as 33 V.S.A. § 1804.

Special Enrollment Period (SEP): A defined time-period, generally 60 days, allowing enrollment and/or plan changes mid-year. SEPs require that an individual experiences a qualifying event as defined in the Qualifying Life Events chart [here](http://info.healthconnect.vermont.gov), (info.healthconnect.vermont.gov) each with its own parameters.

Stand-Alone Dental Plan (SADP) means a dental plan that is not included as part of a QHP.

Vermont Cost Sharing Reduction (VCSR): a cost sharing reduction (CSR) provided in accordance with 33 V.S.A. § 1812(b)(2) by the State of Vermont in addition to the federal CSR.

Vermont Premium Assistance (VPA) is an additional premium reduction paid by the State of Vermont in accordance with 33 V.S.A. § 1812(a) for eligible individual QHP households with eligible income levels.

1.2 Certification Process and Timeline

DVHA's certification process ends with the formal selection by the DVHA Commissioner of QHPs and QDPs to be offered on the Exchange. The date to complete formal certification of plans and all other milestones required of Issuers is published in the Qualified Health Plan Certification Timeline (QHP Timeline), which is updated annually no later than October 31st. Dates within the QHP Timeline document are targets and may be adjusted to allow for extenuating circumstances, as necessary. Issuers and other entities are informed promptly of any changes to the timeline. The QHP Timeline is located [here](#).

1.2.1 Letter of Intent for first year of participation

For prospective new Issuers on the Exchange, a nonbinding letter of intent is necessary to begin communication with the Vermont regulatory agencies involved with the certification process and to begin extensive operational preparation required to incorporate a new Issuer into the Exchange. The due date of the letter of intent is March 31 two years in advance of the beginning of open enrollment for the plan year, as specified in the QHP Timeline.

Issuers of QHPs and QDPs already certified by the DVHA Commissioner are not required to submit a letter of intent; it is presumed that an Issuer will continue participation in the Exchange unless formal notification to the contrary is provided to DVHA.

The letter of intent should be submitted by mail to:

DVHA Commissioner
1 NOB South, 280 State Drive
Waterbury, VT 05676

1.2.2 Initial Plan Design

DVHA engages a broad-based stakeholder group annually to develop a proposal of standard plan designs for GMCB approval. The stakeholder group consists of representatives from DVHA, each Issuer, the Vermont Healthcare Advocate's office, DFR, and the GMCB. Discussion of possible cost benefit changes is guided by DVHA's contracted actuarial professionals who provide plan design modeling using the federal actuarial value calculator (AVC) and incorporating other plan design requirements from the federal notice of payment parameters and other law. Formal approval of the QHP designs from GMCB is the first major milestone in the QHP Timeline.

Following GMCB approval of Vermont's standard QHP designs for the following coverage year, DVHA's contracted actuaries provide an actuarial certification document. This document provides the detailed benefit cost share amounts to be provided in standard plans by each Issuer, at all metal and cost-sharing reduction (CSR) levels and certifies their AV compliance within acceptable ranges. For non-standard plan designs, Issuers are required to follow the same AV guidelines applicable to the coverage year as for standard plans. The process for review and approval of non-standard plans by the GMCB is described in detail below in Section 2.4.3.

Once DVHA releases the standard QHP and QDP benefit designs, Issuers must submit policy forms to DFR for review and approval and QHP rate proposals to GMCB for review and approval. QDPs submit forms and rates to DFR. Deadlines for form and rate submission are included in the annual Certification Timeline Document located [here](#).

When designing plans, Issuers should consider the following:

- The metal and cost sharing levels required for Standard QHP offerings.
- Whether DVHA has issued any requests for Issuers to propose one or more Non-Standard QHPs or QDPs; and
- Whether the Issuer wishes to offer any Non-Standard QHPs or QDPs.

1.2.3 Certification of QHPs and QDPs

The DVHA Commissioner will determine whether certification or recertification of an Issuer's plan(s) and their availability through the Exchange is in the best interest of individuals and employers in Vermont. In determining the best interest, the DVHA Commissioner shall consider:

- Affordability.
- Promotion of high-quality care, prevention, and wellness.
- Promotion of access to health care.
- Participation in the State's health care reform efforts.
- Issuer and plan compliance with the criteria of this guidance and with State and Federal law.
- Historic rate increases; and
- Such other criteria as the DVHA Commissioner deems appropriate.

Upon request by DVHA, Issuers shall provide evidence of satisfaction of certification criteria. Document requests by DVHA relevant to the above shall be reasonable in their scope.

Certification is effective for one calendar year from January 1st through December 31st. It is expected that an Issuer will seek annual recertification of all its currently certified standard and non-standard QHPs and QDPs.

Vermont Issuers are required to offer all standard QHPs as approved by GMCB. If an Issuer intends to add a new plan, to discontinue an existing plan, or to make significant changes to any of their non-standard QHP offerings the Issuer is required to follow the process outlined in Section 2.4.3 of this Guidance.

An overview of the major certification steps, the responsible Vermont agency, and the approximate timing within the annual certification cycle is provided in *Appendix A: Critical Certification Steps for Issuers*.

1.2.4 Term of Engagement

A certified QHP or QDP may be offered through the Exchange. An Issuer shall offer certified QHPs and/or QDPs for a term of one-year beginning on January 1 of the Plan Year and ending December 31 of the Plan Year. Certified QHPs and QDPs will be available for plan selection during AOEP, with a coverage effective date beginning on January 1st of the new Plan Year, or mid-year under a defined SEP. Small Groups that are new to the Exchange may enter the Exchange mid-year to align with the mid-year end date of the group's previous health coverage; ongoing renewal dates for Small Groups is calendar year. Only health plans and SADPs approved by GMCB and DFR and certified by DVHA may be offered as QHPs or QDPs during this period.

1.2.5 Notification for Changes in Plan offerings

The Issuer must notify DVHA by the date specified in the QHP Timeline if it wishes to submit new non-standard plans for certification or if it intends not to seek recertification of any of its currently certified plans. "New non-standard plans" in this context means plans not previously certified as QHPs or modified plans not considered a uniform modification, as determined by DFR.

1.2.6 Participation Agreement, Trading Partner Agreement (TPA), and Electronic Data Interchange (EDI) Testing

A fully executed Participation Agreement is a condition of participation in the Exchange for QHPs and QDPs, as well as successful testing with DVHA of one or more EDI interfaces. Unsuccessful EDI system interface testing in preparation for the annual open enrollment period could jeopardize the certification status for specific QHPs, QDPs, or for an Issuer. QHP and QDP Issuers are required to have a valid, executed TPA(s) in place. TPA(s) may require periodic updating as determined by DVHA.

1.3 Applicability and Changes

The procedures and criteria described in this Guidance do not supersede the responsibility of Issuers to comply with State and Federal Law.

The procedures and criteria described in this Guidance are subject to change as necessary to accommodate changes to processes and requirements of other state and federal authorities. This Guidance may be amended, at DVHA's discretion, to accommodate changes to federal and state law or for administrative purposes such as a change in contact person. DVHA will provide notice to Issuers and an opportunity to respond at least 30 days in advance of any proposed changes to this Guidance, to the extent such notice is allowed by law, regulation, or guidance.

1.4 Vermont Contact Information

Department of Vermont Health Access (DVHA):

Questions related to participation in the Exchange market and plan certification should be directed to DVHA:

Mr. Dana Houlihan, DVHA Plan Management Director

Email: dana.houlihan@vermont.gov

Phone: (802) 585-4140.

Additional Exchange information is available on the Exchange Help Site:

<https://dvha.vermont.gov/budget-legislative-and-rules/regulatory-information>

Department of Financial Regulation (DFR):

Questions related to regulation of health Issuers including licensure, accreditation, and provider credentialing should be directed to DFR:

Emily Brown, DFR, Deputy Commissioner, Insurance

Email: Emily.Brown@vermont.gov

Phone: (802)-828-4871.

Anna VanFleet, DFR, Director of Rates and Forms, Life & Health

Email: Anna.VanFleet@vermont.gov

Phone: 802-828-4843

Additional information is available on DFR's website or by contacting the department:

- DFR website: <https://dfr.vermont.gov/industry/insurance/health-insurance>
- DFR Phone: (802) 828-3301

Green Mountain Care Board (GMCB):

Questions related to standard and non-standard benefit design approval and the QHP rate review and approval process should be directed to the GMCB:

Laura Beliveau, GMCB Staff Attorney

Email: Laura.Beliveau@vermont.gov or

Phone: (802) 636-7024.

Additional information can be found by contacting the GMCB:

- GMCB website: <https://gmcboard.vermont.gov/>
- GMCB Phone: GMCB Phone: (802) 828-2177.
-

Section 2 QHP Certification Standards

An Issuer and its QHPs, Reflective plans, and QDPs, as applicable, must satisfy the criteria detailed in this section before its plans will be certified. Failure to maintain compliance with these standards may result in decertification of the Issuer's QHPs.

2.1 QHP Issuer Licensure

Issuer must be licensed in Vermont through DFR and remain in good standing throughout the Plan Year.

If DFR has restricted the Issuer's ability to offer current or new health plans, DVHA will determine, consistent with DFR restrictions, if the Issuer's plans may be granted certification or recertification.

2.2 Required Enrollment Categories

The Issuer must provide the following coverage categories: single person, couple, adult and dependent(s), and family (two adults and dependent(s)). [DFR Docket 13-002-1](#).

2.3 Service Area

The plan Service Area shall encompass every ZIP code in the State of Vermont.

2.4 Benefit Design Standards

QHP Issuers must offer all standard benefit design plans as approved by the GMCB and subsequently certified by DVHA. Issuers may also provide non-standard plans certified by the DVHA Commissioner. DFR reviews all standard and non-standard plan design documents to ensure compliance with applicable federal and State of Vermont requirements.

QHP Issuers must provide the services listed in the Vermont EHB Benchmark Plan, as approved by the GMCB. The Vermont EHB Benchmark Plan, first selected in 2014 and subsequently updated effective in the 2024 plan year, complies with all federally required essential health benefits (EHB) provisions and incorporates additional benefits required by the State of Vermont. Vermont's EHB Benchmark Plan information may be found [here \(info.healthconnect.vermont.gov\)](http://info.healthconnect.vermont.gov). A list of State of Vermont required benefits extending beyond federally required EHB may be found [here](#). The process and timeline to change the Vermont benchmark plan is posted on the DVHA website [here](#).

All QHPs certified by DVHA must provide embedded pediatric dental and vision coverage for children up to age 21.

NOTE: In August 2022, Centers for Medicare & Medicaid Services (CMS) approved changes to Vermont's essential health benefits (EHB) benchmark plan proposed by DFR and DVHA. The new EHB benchmark plan includes coverage for hearing aids, alleviates unnecessary restrictions on benefits such as nutritional counseling and rehabilitative services and clarifies coverage requirements for certain benefits that are included in the current EHB benchmark plan. The approved changes will take effect in the 2024 Plan Year.

2.4.1 Required Metal Tiers for Standard Plan Designs

Issuers must offer all standard plans designed by DVHA through the stakeholder process and approved by the GMCB. Such plans must be offered at the following metal levels: platinum, gold, silver, and bronze. Currently, Vermont offers a deductible plan at each of the Platinum, Gold, and Silver metal levels, with two at the Bronze level, and a High Deductible Health Plan (HDHP) at each of the Silver and Bronze levels. The plan cost share amounts are adjusted annually through the stakeholder process to comply with federal AV standards, following the release of the federal AVC, as specified in the QHP Timeline. Further details and examples of standard QHPs on the Exchange as well as each issuer's non-standard plans, as described in Section 2.4.3 below, may be found [here \(info.healthconnect.vermont.gov\)](http://info.healthconnect.vermont.gov).

2.4.2 Approval of Standard Plans

Incorporating stakeholder input, DVHA prepares a proposal, with guidance from DVHA's contracted actuaries, of the standard QHP plan designs annually in January for presentation to the GMCB. Proposed changes to cost share amounts are made each year to maintain AV compliance and to incorporate any additional federal or State of Vermont requirements. Following GMCB approval, DVHA's actuaries prepare an AV Certification Document for Issuers with detailed instructions for completion of all standard plans including Silver CSR and Reflective plans.

Issuers must offer QHPs in all required CSR and American Indian / Alaska Native (AI/AN) variants for all metal levels. DFR reviews the associated plan documents (certificates, summaries of benefits and coverage) and approves that all are compliant with the requirements. Issuers must also calculate the EHB percentage for each QHP and provide those amounts within the SERFF binder filings. Premium subsidy is calculated using the EHB percentage.

2.4.3 Requirements Related to Non-Standard Plans

Submission of innovative, non-standardized plan(s) is encouraged, but optional. GMCB reviews and approves proposals for new, or for substantial changes to existing, non-standard QHP designs exceeding the federal definition for uniform modifications. The approval process and specific criteria can be viewed on the DVHA website [here](#).

Non-standard plans must also comply with actuarial value standards using the federal AVC methodology for the corresponding year, with appropriate, fully documented adjustments. DFR's annual review and approval process ensures that non-standard QHP provide all federally required essential health benefits (EHBs), compliance with benefits and provisions of Vermont's benchmark plan, and must be in adherence with all other federal and State of Vermont regulations.

Issuers may offer Non-Standard QHPs at any or all metal levels. DVHA will consider the total number of plans per metal level in making its certification decision.

2.4.4 Individual Plan Availability for Individuals Less than 21 Years Old

In Vermont, where there is no age rating, medical QHP Issuers must allow enrollment in the single person enrollment category to eligible individuals, including individuals who have not yet reached the age of 21, even in the absence of a parent covered by the policy. For households enrolling multiple children without also enrolling one or both parent one single person policy must be purchased per dependent child under age 21.

2.4.5 Plan Accumulators

Accumulators (deductible and out of pocket maximum amounts) reset for all Enrollees at the beginning of each Plan Year on January 1st. Issuers shall credit accumulators for QHP Enrollees who change plans mid-year during a SEP with the same Issuer. This requirement does not apply to Enrollees who re-enroll after a break in coverage, or who select a QHP with a different Issuer. This requirement may include Enrollees who move between the Small Group and Individual QHP markets if coverage remains with the same Issuer, in the same metal level and plan.

2.4.6 Vermont Cost Sharing Reduction (VCSR)

In accordance with state statute (33 V.S.A. § 1812), the VCSR program is modeled after the federal CSR program and is calculated using the same method except that with silver loading in place, the *Reflective* (lower) silver rates are used in the formula to calculate VCSR. DVHA pays the VCSR on behalf of Enrollees to QHP Issuers prospectively for Enrollees in VCSR-level silver plans purchased through the Exchange. QHP Issuers shall actively engage with DVHA in the annual claims-based reconciliation process that begins in the second quarter of the following Plan Year to determine if DVHA has made an over- or under-payment. Reconciliation may result either in additional VCSR payment due to an Issuer, or reimbursement from an Issuer to DVHA if it is determined that an overpayment was made.

If the reconciliation determines that an underpayment was made, DVHA shall submit payment to the Issuer. If an Issuer has been overpaid, DVHA will invoice the Issuer for the payment and Issuer shall timely submit payment to DVHA. Payment by either party shall be made within 30 days of invoice. If an Issuer disagrees with the reconciliation or invoiced amount, they shall notify DVHA within 30 days.

2.5 Review of Summary of Benefits and Coverage (SBC) and Plan Documents

Issuers are responsible for submitting to DFR all required plan documents and forms including the SBC for their review and approval. The deadline for Issuers to submit plan documents to DFR is provided annually in the QHP Certification Timeline.

Issuers must provide up-to-date plan documents to Enrollees or applicants either by viewing them online through their website or on paper by request free of charge. If mid-year changes are required to plan documents to maintain compliance with federal and state law, Issuers must re-submit forms to DFR

for approval, and provide the approved, updated documents to Enrollees as soon as possible, but no later than 30 days after DFR approval.

The Exchange will provide access by direct link to SBCs for all on-Exchange plans in the current Plan Year, and for the upcoming Plan Year during the annual open enrollment period, AOEP, via its online application and on its informational website. Issuers are expected to ensure that all content is up-to-date and reflects accurate information prior to open enrollment.

Issuers are required to maintain SBC and Uniform Glossary documents in the standard format as directed by HHS. HHS resources on SBCs, including a standard SBC form, may be found [here](#).

2.6 Compliance with Non-Discrimination Laws

An Issuer must not engage in unlawful discrimination on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Issuers must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. Marketing and communications activities by Issuers must also comply with federal and state standards concerning those with Limited English Proficiency (LEP) and disabled populations.

Issuers must provide all information that is critical for obtaining health insurance coverage, as defined in 45 C.F.R. § 156.250, to applicants and enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and individual who are LEP. For individuals living with disabilities, accessible websites and the provision of auxiliary aids and services must be provided at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. For individuals with who are LEP, information is accessible when language services are provided, at no cost to the individual, including oral interpretations, written translations, and the provision of taglines in non-English languages indicating the availability of language services.

2.7 Accreditation

Issuers must obtain and maintain accreditation for each QHP from an accrediting entity recognized by HHS. Issuers must authorize the accreditation entity to release to DVHA and HHS a copy of the QHP's most recent accreditation survey with any survey-related information that HHS may require.

In addition to the requirements outlined in the Vermont Consumer Protection and Quality Requirements for Managed Care Organizations rule (Rule 09-03), available [here](#), Issuers must submit proof of QHP's accreditation to DVHA according to the QHP Timeline. This can be done by providing DVHA with a copy of the QHP's current certification certificate, or other written attestation of current accreditation status from the National Committee for Quality Assurance (NCQA) or other entity recognized by HHS pursuant to 45 CFR 156.275. QHPs in their first year of participation on the Exchange may achieve compliance with this criterion by obtaining and submitting their timeline to attain accreditation, and proof of accreditation after certification in accordance with the timeline.

Issuers must contact DVHA within two business days if there is any change in QHP accreditation status or if up-to-date accreditation is discontinued.

2.8 Marketing Materials

2.8.1 Review of Materials

Issuers must submit materials for review by DVHA at least 10 business days prior to dissemination, including both of the following:

- Communications which relate to plans, or the activities and workings of the Exchange directed towards Enrollees, former Enrollees, potential enrollees, businesses, and their Employees in small group coverage; and
- Materials using the copyrights and trademarks of the Exchange or featuring logos or symbols created for the Exchange operations or communications purposes.

Review is not required for materials which are limited to the following:

- Exchange-related written documentation already approved by DFR or GMCB.
- The Issuer's general or promotional materials which do not materially address the Exchange, including non-Exchange specific advertising, employer, or Employee newsletters.
- Ad hoc communications intended for a specific Enrollee or an identifiable subset of Enrollees with a unique situation.
- Explanations of benefits or other documents addressing coverage and claims of a specific individual.

2.8.2 Review Process

Materials may be disseminated 11 business days after submission to the Exchange, unless:

- DVHA notifies the Issuer that more time is needed for review; or
- DVHA issues an objection within 10 business days to materials which it reasonably considers misleading, inaccurate, or non-compliant with law, stating the reasons for its objections and any changes required.

Issuers may request expedited review of materials, but DVHA is not obligated to grant such a request. Issuers must demonstrate exceptional circumstances that merit expedited review and must request expedited review at the time of submission of the materials.

Issuers must send final copies of approved materials at least one business day in advance of dissemination to the email address: ahs.dvhacommunications@vermont.gov

2.8.3 Identification Cards

All Enrollee identification cards must contain the Exchange logo and a toll-free number of the Exchange Customer Support line for the Individual Market or Small Group coverage, as applicable. This standard

does not apply to cards issued to individuals who enroll in a health plan directly through the Issuer off-exchange.

Additional identification card requirements are listed in DFR regulation [H-2008-04](#).

2.8.4 Issuer and Exchange Logos

Issuers may not alter or substitute the Exchange logo.

As a condition of certification, QHP Issuers agree to cooperate with DVHA to grant or obtain the use of Issuer logos on the Exchange application and in customer outreach materials drafted by the Exchange and acknowledge that their logos may be displayed through the Exchange. Issuers will be able to review any Exchange marketing materials that use the Issuer's logo prior to distribution. DVHA agrees to allow Issuers of QHPs and QDPs use of the Exchange logo for Exchange related communications. Issuers shall submit any materials using the Exchange logo to DVHA for review in accordance with Section 2.8.1 above.

2.9 Network Adequacy

The networks associated with plans offered on the Exchange will be evaluated by DFR to ensure the network meets all federal and state legal requirements. Issuers should refer to federal and state law and regulation, including DFR Rule [H-2009-03](#) for additional requirements related to network adequacy.

2.10 Provider Directory

Issuers must provide access to an online provider directory specific to the QHP for each Plan Year. Issuers shall update the provider directory whenever new information becomes available, but not less frequently than monthly. The online provider directory must be accessible to both Enrollees and applicants without the use of an Enrollee login or policy number. Issuers will notify DVHA of the location of this directory when the Issuer annually submits the SBCs and when the location is updated so that it can be accessed by a link on the Exchange website and application.

Issuers must provide, free of charge, a hard copy of the current provider directory to a potential Enrollee or Enrollee upon request.

2.11 Formulary

Issuers are responsible for providing complete and continually up-to-date formulary information to their Enrollees by posting the formulary on their website. Per DFR Rule I-2016-01, Issuers shall ensure that the formulary is searchable by Enrollees, potential Enrollees, and health care providers. DFR reviews Issuer formularies as part of its annual form approval process to ensure that coverage and written materials are appropriate. The Exchange's online application portal, its help site, and online plan comparison tool contain links to connect applicants and Enrollees to the Issuer's formulary information. Issuers will notify DVHA of the online location of the formulary so that it can be accessed by a link on the Exchange website. Enrollees may also request printed formulary information from Issuer who must provide the information free of charge.

2.12 Quality Requirements

Vermont QHP Issuers must comply with the Quality Improvement Strategy (QIS) and Quality Rating Strategy (QRS) programs as required by CMS. Further detail for both programs is provided below. The QIS and QRS programs are not required for QDPs.

2.12.1 Quality Improvement Strategy (QIS)

Any eligible QHP Issuer participating on the Exchange for two or more consecutive years and that meets the minimum enrollment threshold must implement, and provide annual reporting on, a Quality Improvement Strategy (QIS) to DVHA. Issuers may implement one QIS that applies to all eligible QHPs on the Exchange or may implement more than one QIS. A QIS may be directed to address the needs of all Enrollees in a particular QHP or may be directed at specified sub-populations.

DVHA follows the outline provided within federal guidance for QIS as described in the *Quality Improvement Strategy: Technical Guidance and User Guide* (QI Technical Guidance), issued by CMS annually. QHP Issuers should refer to the timeline, scoring outline, and other evaluation elements as described within the Technical Guidance document. QHP Issuers must submit QIS plan details and annual evaluation documentation via the SERFF system using the *QIS Implementation Plan and Progress Report Form* (QIS Report) provided annually by CMS. The report is included as a supplemental document in fillable PDF format within SERFF for the annual submissions.

Issuers shall submit the annual QIS Report form as directed in the QHP Timeline.

2.12.1 Quality Rating System (QRS)

Distinct from the QIS, the QRS is based on relative quality and price of QHPs. DVHA is required to display the QRS scores of each QHP on the Exchange website to assist in consumer selection of QHPs.

Issuers must implement Enrollee satisfaction surveys on an annual basis consistent with ACA § 1311(c)(4) and 45 CFR § 156.200(b)(5). CMS collects and analyzes results from the annual Enrollee satisfaction survey and other quality metrics to develop QRS star ratings. DVHA receives star ratings for Vermont Issuers from CMS in advance of the Annual Open Enrollment Period and publicizes ratings on its website and within an online plan comparison tool.

2.13 Attestation

Before a QHP is certified by DVHA, Issuers must attest to compliance with all QHP operational requirements under 45 C.F.R. 156 Subpart D, E, H, K, L, and M. Vermont Issuers complete the attestation form to fulfill this requirement and submit annually through SERFF filings.

2.14 Enrollment Process Overview

Questions regarding enrollment may be directed to the Exchange website [here](#), or by calling the Exchange Customer Service at 1-855-899-9600.

2.14.1 Individual Market Enrollment

Customers may apply for coverage through the Exchange using one of multiple channels including a paper application, an online application, or with in-person assistance from individuals throughout Vermont trained by the Exchange. Customers may also apply for coverage directly through the Issuers. The Exchange's application system is designed to screen applicants for the Medicaid Program or enrollment in a plan with or without financial assistance, depending upon household income. Applicants in the individual market must enroll through the Exchange for determination of eligibility for subsidies. If eligible for subsidies, applicants must enroll in a plan through the Exchange to receive APTC, Vermont Premium Assistance, and Cost Sharing Reductions. Applicants may enroll in coverage directly with the Issuer but will not be eligible for premium subsidy or cost sharing assistance for months enrolled directly through an Issuer. It is expected that issuers will highly encourage screening through the Exchange especially because of the expanded financial assistance under the American Rescue Plan Act for which most Vermonters are eligible.

2.14.2 Acceptance of enrollment and provision of benefits to Qualified Individuals

Vermont is a guaranteed issue state. Once each plan is certified, the Issuer will offer and allow Qualified Individuals to enroll in the plan and provide benefits to all Enrollees in that plan for the applicable Plan Year regardless of failure to pay premiums in the previous Plan Year.

The following risk classification factors are prohibited from use in rating individuals, Small Group employers, or Employees of Small Group employers, or the dependents of such individuals or Employees:

- demographic rating, including age and gender rating.
- geographic area rating.
- industry rating.
- medical underwriting and screening.
- experience rating; or
- durational rating.

2.15 Posting Justifications for Premium Changes

In Vermont, the GMCB is the entity authorized to perform the QHP rate review and approval process, which typically takes 90 days. Issuers must provide detailed premium change justifications as part of their annual rate filing and DFR submits a solvency opinion to the GMCB for each Issuer by day 60 of the rate review process. The GMCB completes detailed analysis of each rate filing and conducts a formal hearing for Issuers to present their proposed rate changes, to hear testimony from the Office of the Health Care Advocate regarding the proposed rate changes, and to hear testimony from DFR on the Issuers' solvency. The GMCB provides a thorough public comment period before issuing a formal order to each Issuer approving, approving with modification, or disapproving a requested rate change. The GMCB posts each Issuer's premium change justification on its website for public review and accepts public comments until a minimum of 15 days following the public posting of both DFR's solvency opinion and the GMCB's actuarial memorandum. Past rate decisions of the GMCB may be viewed [here](#). Rate

review processes and applicable statutory and regulatory requirements for GMCB rate review may be viewed [here](#).

2.16 Information reported in SERFF

Issuers are required to utilize the standard, federally provided SERFF templates to submit plan benefit, rate, and several other templates and documents as part of the annual QHP certification process. DVHA provides Issuers annually with written instructions listing required documents and references to updated templates for binder submissions in SERFF. The GMCB uses the rate information as part of its rate review and approves the final rate change in SERFF. DVHA will use information from these templates to update plan information for the upcoming Plan Year in preparation for the annual open enrollment period. CMS also accesses the templates for information needed to administer reimbursement programs and for other federal reporting purposes. Issuers are responsible for the accuracy and timeliness of SERFF file submissions; information within the files will not be altered by DVHA or other Vermont regulatory entities.

2.17 Other Reporting

Issuers offering plans through the Exchange must also provide enrollment, payment, and termination data as reasonably required by DVHA as necessary to support Exchange operations, including but not limited to:

- Individual enrollments and terminations
- Tax Reporting (1095A)
- Information required by the U.S. Department of Health and Human Services, or the Internal Revenue Service
- Information the Vermont Legislature requests from DVHA, needed from the Issuers; and
- Small Group enrollment information, as needed.

2.18 Notices and Forms

Issuers are responsible for communicating with their Enrollees by providing notices, including the following:

- Initial enrollment information including benefit and policy materials and ID cards;
- Dunning notices;
- Termination notices including the effective date of termination for affected Enrollees;
- Notices of mid-year benefit, provider network, plan administration changes, as needed and required; and
- Renewal notices including benefit changes and premium amount for Enrollee's current plan in the renewal year.

2.19 Customer Complaints & Appeals

For assistance with plan enrollment, eligibility, and subsidy questions or complaints, applicants and existing Enrollees should be directed to contact the Exchange Customer Service phone line. Customers with premium billing questions may contact their Issuer directly. Issuers and the Exchange will work collaboratively to resolve customer matters rooted in a combination of eligibility and billing issues.

If an eligibility or subsidy matter is not resolved through the Exchange Customer Service to the individual's satisfaction, information is readily available for them to initiate a formal appeal through the Vermont Human Services Board. Appeal process information is included in the Exchange's customer notices and is posted on the online Exchange Help Site [here](#).

If a premium billing matter is not resolved by the Issuer to the individual's satisfaction, the individual may file a complaint with the Vermont Department of Financial Regulation (DFR). Information regarding initiation of the consumer complaint process is posted on the DFR website [here](#).

2.20 Audits

Full participation and cooperation between Issuers on the Exchange and DVHA is required to complete reasonable periodic audits conducted by DVHA or audits conducted by the State of Vermont or from third-party entities. Audits may consist of, but are not limited to, the following:

- Enrollment and termination reconciliation;
- Reconciliation of premium, federal, and State subsidy amounts; or
- Administration of QHP benefits.

2.21 Premium Processing

Premium processing is performed by the Vermont issuers for their Enrollees in accordance with federal and State of Vermont requirements. Issuers may refer to the Issuer Policy & Operations Guide which provides further description, citations, a list of process requirements, and process flow diagrams related to premium billing. The Issuer Policy & Operations Guide may be found on the DVHA website [here](#).

2.22 Customer Service

Issuers participating in the Exchange are expected to provide superior, high-quality service to all customers including Enrollees, providers, and other business partners. As noted in Section 2.7, Issuers must achieve and maintain full accreditation with a nationally recognized accrediting entity such as NCQA; the Issuer's customer service rating is a significant component of accreditation. DFR receives and responds to formal complaints from enrollees, providers or other business partners that are not resolved satisfactorily by the Issuer. Customer service-related issues that negatively affect an Issuer's accreditation status, or its good-standing and licensure through DFR jeopardize an Issuer's certification status for participation in the Exchange.

2.23 Risk Stabilization Program

A QHP Issuer must comply with the requirements of the risk adjustment program as specified in the ACA standards set in federal rules 45 CFR part 153, the annual Notice of Benefit and Payment Parameters published by the Department of Health and Human Services (HHS), and other applicable law.

2.24 Small Business Health Options Program (SHOP)

In Vermont, businesses with 100 or fewer Employees may enroll in QHPs certified by DVHA. Except for the Catastrophic plan, which is only available to individuals, the same array of QHPs is available to the individual and Small Group markets. Rate filings are completed separately for Small Group and individual market segments with a separate review, hearing and approval process through the GMCB. Premium billing for Small Groups and their Employees as well as for individual market Enrollees is done exclusively through Vermont's Issuers.

Section 3 Qualified Dental Plan (QDP) Certification Standards

Only QDPs certified by DVHA may be offered on the Exchange. A dental plan Issuer may also offer non-certified SADPs off-Exchange that are not subject to the requirements of this Guidance and that are rated separately. An Issuer offering certified QDPs on the Exchange is required to comply with all relevant state and federal laws and regulations including those set forth in 45 CFR parts 155 & 156.

DFR is responsible for review and approval of dental plan forms and rates. Issuers shall maintain compliance with standards required by DFR for certification including those found in [DFR Regulation I-1980-01](#).

3.1 Certification Standards Applicable to QDPs

An Issuer and its QDP must satisfy the certification criteria detailed in Section 2, including the following, to be certified as a QDP for participation on the Exchange:

Section 2 §	Overview of criteria contained in referenced section.
2.1 Issuer Licensure	Issuer must be licensed in Vermont through DFR.
2.3 Services Area	The Service Area shall encompass every ZIP code in Vermont.
2.5 Review of SBC and Plan Documents	Issuers must submit all required QDP documents to DFR for review and approval.
2.6 Compliance with Non-Discrimination Laws	Issuers must comply with non-discrimination rules.
2.8 Marketing Materials	Issuers must submit materials for review by DVHA.
2.10 Provider Directory	Issuers must provide access to an online provider directory and provide a hard copy upon request.
2.14.2 Rating Restrictions	Limitations on risks factors that can be used in rating customers.
2.16 Information reported on SERFF	Issuers are required to utilize SERFF as part of the certification process.
2.17 Other Reporting	Issuers are required to provide reports to the Exchange as necessary to support Exchange operations.
2.18 Notices and Forms	Issuers are responsible for communicating with Enrollees, as necessary.
2.19 Customer Complaints & Appeals	Process for processing customer complaints and appeals.

2.20 Audits	Issuers are required to fully participate and cooperate with DVHA to complete periodic audits.
2.21 Premium Processing	Issuer is responsible for premium processing in compliance with federal and State of Vermont requirements.
2.22 Customer Service	Issuers are expected to provide superior, high-quality customer service to all customers.

In addition to the above Section 2 standards applicable to QDPs, an Issuer and its QDPs must satisfy the following dental plan specific criteria before a QDP may be certified and shall be subject to provisions in Section 1, 4, 5, and 6.

3.2 QDP Enrollment Process Overview

In addition to the enrollment requirements in this section, QDP Issuers must comply with enrollment requirements as outlined in Sections 2.14.1 and 2.14.2 of this document.

3.2.1 Required Enrollment Categories

QDP Issuers must provide the following rate tiered coverage categories:

- Tier I: Single consisting of one person.
- Tier II: Two Person which may include two adults or an adult and child between the ages of 21 and 26.
- Tier III: Single Head of Household with one or more children under the age of 21.
- Tier IV: Family consisting of two or more adults 21 years or older with child(ren) under the age of 21 or three or more adults ages 21 and older.
- Tier V: Child Only (one child under the age of 21); and
- Tier VI: Child Only (two or more children under the age of 21).

3.2.2 Individual Dental Plan Availability for Individuals Less than 21 Years Old

QDP Issuers must provide a separate rate tier level for children who have not yet reached the age of 21, even in the absence of a parent covered by the policy.

3.3 QDP Benefit Design

The benchmark plan selected for Vermont is the Child Health Insurance Program (CHIP) located here : <https://www.medicaid.gov/medicaid/benefits/dental-care/index.html>. All benefit design offerings must include all elements of the benchmark plan and must also comply with federal requirements related to QDPs, Actuarial Value (AV) standards, and must meet Vermont regulatory and statutory requirements.

QDP Issuers must offer all QDPs that have been approved by DFR and certified by DVHA for participation in the individual, or the small group market, or both through the Exchange. All QDPs submitted for certification by DVHA must include the pediatric dental EHB as defined under ACA §1302(b) and required by 45 CFR §155.1065. A QDP covering pediatric dental EHB under 45 CFR § 155.1065 must limit cost sharing for pediatric dental coverage in accordance with 45 CFR §156.150. Vermont’s dental

issuer(s) must also provide a QDP for adults aged 21 and older, and for children under age 21 who do not have a QHP.

3.4 Posting Justifications for Premium Changes

QDP issuers must submit comprehensive average rate increase proposals with all supporting documentation to DFR for review and approval.

DFR is the entity authorized to perform QDP rate review and approval process, which typically takes 30 days. Issuers must provide actuarial justification as part of their annual rate filings. DFR analyzes the proposed rate change for compliance with federal and state law. The public has access to the annual rate filing through [SERFF](#).

Section 4 Compliance Monitoring and Decertification

Issuers offering plans on the Exchange are required to maintain compliance with certification standards throughout the Plan Year. DVHA may decertify plans for failure to maintain compliance with certification standards, generally only after notice and an opportunity to cure. Issuers and DVHA will maintain communication and cooperation to address or resolve compliance issues suspected or anticipated by DVHA.

Issuers may also be required to respond to compliance inquiries, produce requested evidence, or take remedial actions as necessary to ensure ongoing compliance with this guidance and applicable law throughout the Plan Year.

4.1 Compliance Monitoring

4.1.1 Initiation

DVHA will initiate compliance inquiries as necessary to determine an Issuer's compliance with the certification standards applicable to its plans and participation in the Exchange. The inquiry notice will contain:

- A description of the problem, issue, or question identified by DVHA.
- Reference to the applicable law, rule, or standard.
- The form of response expected of the Issuer.
- The timeframe for response; and
- Contact information for the DVHA staff responsible for resolving the compliance inquiry.

DVHA shall promptly respond to Issuer questions related to compliance inquiries, allow for reasonable extensions of response timeframes, and, when feasible, meet with Issuers to review draft responses to compliance inquiries.

4.1.2 Issuer Response

DVHA shall narrow or resolve a compliance inquiry if the Issuer provides documentation or additional information resolving one or more of the issues identified. If the inquiry remains open, the Issuer must respond to the compliance inquiry within the timeframe established in Section 4.1.1. The formal response shall address any action identified in the inquiry as reasonably necessary for the Issuer to demonstrate or establish compliance with the standards identified in the Inquiry.

DVHA will notify the Issuer within 15 calendar days of Issuer's response submission if DVHA needs additional action from Issuer, including production of additional evidence or revision of the proposed corrective action plan, request additional time for review, or any other action. If DVHA requests additional action or additional time to review, DVHA will specify a new timeframe for resolution.

4.1.3 Compliance Inquiry Conclusion

DVHA will conclude a compliance inquiry once compliance has been established or a corrective action plan has been approved for each issue identified or upon expiration of the applicable timeframe. If, at the conclusion of the inquiry, DVHA believes the Issuer is out of compliance with the applicable standards, DVHA may take additional actions, up to and including decertification.

DVHA may also conclude a compliance inquiry at any time by referring the matter to another agency.

4.2 Decertification

Decertification can apply to a single QHP, to multiple QHPs, or to an Issuer. Unless required by the circumstances, decertification of QHP(s) or of an Issuer will be effective at the end of a Plan Year.

4.2.1 Process

DVHA will decertify plans if it determines, based on its own investigation or another department's action, that the QHP or its Issuer no longer meets certification requirements of this Guidance or applicable law. Generally, DVHA will pursue a compliance inquiry and provide the Issuer with notice and an opportunity to cure prior to initiating the decertification process. Due to the disruption to both an Issuer and its members, DVHA will generally endeavor to work with the Issuer to correct any deficiencies in lieu of decertification.

DVHA is not required to initiate or complete a compliance inquiry, and may decertify a plan or plans, if it reasonably determines that no corrective action on the part of the Issuer would achieve sufficient compliance with the applicable standards and that immediate decertification, subject to relevant appeal rights, is necessary. Those circumstances include, but are not limited to:

- Instances where the Issuer is no longer authorized to sell or provide insurance in Vermont.
- Where action by another governmental entity warrants immediate decertification because, based on the action taken, no corrective action plan would cure the violation.
- Violations of Vermont laws, rules or regulations that are so egregious as to warrant immediate decertification.

Technical violations of this Guidance do not generally warrant immediate decertification of an issuer.

4.2.2 Appeal

1. Issuers may appeal a decertification. Timely filing of an appeal shall stay enforcement of the decision to decertify an Issuer's plan or plans.

2. To initiate an appeal, Issuer must submit a letter to the Commissioner of DVHA within thirty (30) days of receipt of notice of decertification. The letter must state the reasons for appealing the decertification. Should the letter fail to explain the reasons for the appeal, the Commissioner may reject the appeal or request the letter be revised to include the reasoning of the appeal. Such request will not make the receipt of the appeal untimely.
3. The appeal is considered a “contested case” under 3 V.S.A. § 809.
4. After receipt of the appeal, DVHA will appoint a hearing examiner.
5. The hearing examiner will manage the case, conduct the hearing, and make recommendations to the Commissioner.

Denial of appeal by the Commissioner shall be deemed to be an exhaustion of administrative remedies under the Vermont Administrative Procedures Act (VAPA). 3 V.S.A. §§ 809 et seq. The Commissioner’s notice of denial of appeal shall inform the Issuers of their rights under the VAPA to appeal and to request an immediate stay of the Commissioner’s administrative action with the Vermont Supreme Court.

Nothing in this section prohibits the parties from resolving a notice of decertification prior to issuance of a final written decision.

4.2.3 Notice

DVHA will notify the Issuer, DFR, and HHS directly in writing following a decertification decision.

The notice of decertification will identify the affected plan or plans, the effective date of decertification, the reason for decertification, the process for enrollees to enroll in a new plan, and in the case of notice to Issuer, the appeals process for decertification.

Section 5 Recertification and Renewal of Issuer Participation

5.1 Recertification

If an Issuer intends to recertify an existing plan, an Issuer is not required to notify DVHA of its intention to seek recertification for the following plan year. All QHP identification numbers carry over unchanged from one year to the next.

5.2 Recalculation of plan cost sharing amounts following federal revision of AV requirements

Issuers are responsible for updating benefit cost share amounts within their plans annually to comply with the AV requirements within the annual payment notice, to the extent federal guidance from CMS and from the IRS is available, before submitting their plans for rate and form review. Depending on the timing of publication of federal guidance, issuers may be required to amend form or rate filings after initial submission. Upon receipt of final federal guidance from CMS and the IRS, additional changes may be required to plan documents and rate submissions may also be affected. Refer to the annual QHP Timeline [here](#) for specific submission date requirements.

5.3 Rate changes and justification

Issuers must receive annual rate approval from GMCB. Issuers must post the justification for annual rate changes submitted in the rate approval process on their Web site.

5.4 Auto-renewal of existing enrollees

During the Annual Open Enrollment Period, existing enrollees may select a different QHP for the following plan year. If no selection is made, the enrollee shall be automatically enrolled into the same QHP, meaning the same plan, same Issuer, and the same metal-level, for the following Plan Year.

If a QHP is discontinued from the current Plan Year into the new year, DVHA will determine a re-enrollment procedure for existing enrollees in consultation with QHP Issuers and DFR, subject to CMS approval pursuant to 45 CFR 155.335(a)(2)(iii).

5.5 Decision not to seek recertification

If a QHP Issuer elects not to seek recertification of a plan or of multiple plans, the plan will not be available to users of the Exchange in the upcoming plan year or during open enrollment. The Issuer is required to prepare a mapping plan for approval by DVHA proposing the most similar alternative plan at the same metal level to move impacted Enrollees into for the following Plan Year. Issuers are also required to provide written notice to impacted Enrollees of the plan discontinuation 90 days prior to the end of the Plan Year, and full details of the alternative renewal coverage. As always, eligible Enrollees have the full choice of available plans to select from for the upcoming year during the Annual Open Enrollment Period.

If an Issuer elects not to seek recertification with DVHA, the QHP Issuer, at a minimum, must:

- Notify DVHA of its decision prior to the deadline for filing forms with DFR;
- Fulfill its obligation to cover benefits for each enrollee through the end of the Plan Year through the Exchange including care required due to pre-termination hospital admission;
- Fulfill data reporting obligations from the last Plan Year of the certification; and
- Provide notice to enrollees and coverage in accordance with Section 6.

5.6 Denial of Recertification

With the goal of preserving stability within the Vermont individual and Small Group markets, DVHA generally recertifies existing QHPs and QDPs to be continued in the upcoming Plan Year. The DVHA Commissioner may exercise his/her/their authority to deny recertification if deemed necessary based on criteria described in Section 1.2.3 of this document. If recertification of a plan is denied, DVHA will provide the QHP Issuer notice of denial of recertification as expeditiously as possible, but in no instance later than such time as affirmative certification is communicated for other QHPs and Issuers. This is generally done in early September, according to the QHP Timeline, well in advance of the start of open enrollment. If a QHP is denied recertification by DVHA, the QHP Issuer must provide notice and coverage according to Section 6.

5.7 Market exit

If a QHP Issuer intends to exit the individual and/or small group market entirely, it must provide written notice to DVHA. In addition, Issuers must provide separate notice to inform each Enrollee and/or Small

Group that all of the Issuer's QHPs in the individual and/or Small Group market will be discontinued at least 180 days before the date coverage will expire.

Section 6 Obligations with respect to enrollees upon non-renewal, non-recertification, decertification, and market exit

6.1 Notification Deadline

- Issuers deciding not to seek recertification of a plan must provide notice to Enrollees no less than 90 days prior to the end of the Plan Year.
- Issuers denied recertification must provide notice to Enrollees 90 days prior to the end of the Plan Year. If the recertification denial is received later than 90 days prior to the end of the Plan Year, Issuer shall notify Enrollees as soon as reasonably possible.
- Issuers voluntarily exiting the market entirely must provide notice to Enrollees no less than 180 days before the end of the Plan Year.
- Issuers whose plan or plans have been decertified must collaborate with DVHA to notify Enrollees in the affected plan or plans.

6.2 Contents of notification

Notifications to Enrollees that a plan has been discontinued must explain the reason why their plan has been discontinued and provide instructions for enrollment in a new plan through open enrollment or a special enrollment period, as applicable. Such notices shall be consistent with state and federal law.

6.3 Continuing Coverage After Decertification

Issuers shall provide coverage under a decertified plan through the end of the Plan Year, in accordance with federal and state regulation, unless a plan's decertification is effective before the end of the Plan Year. If decertification of a plan is effective prior to the end of the Plan Year, an Issuer who appeals decertification of its plan or plans may not terminate Enrollees from affected plans until all administrative appeals, as provided for in Section 4.2 of this Guidance, are resolved.

APPENDIX A: Critical Certification Steps for Issuers

Certification Criteria	Criteria Level (Issuer or QHP Product)	Initial Criteria?	Ongoing Certification Criteria?	State of Vermont Agency Responsible for Review	Apply to QDPs?	Timing Within Annual Timeline
Letter of Intent from Issuer.	Issuer	Yes	No	DVHA	Yes	March 31 of second prior year (i.e. in 2022 for coverage beginning in Plan Year 2024)
Obtain and continually maintain VT license to offer insurance.	Issuer	Yes	Yes	DFR	Yes	No later than March (align with form-filing)
Establish timeline for initial accreditation of Vermont Exchange product line with nationally recognized accrediting agency.	All Vermont products	Yes	No	DVHA	No	No later than March (align with form-filing)
Maintain continual accreditation as an Issuer in compliance with State of Vermont requirements.	All Vermont Products	No	Yes	DFR	No	Ongoing
Participate in stakeholder process to formalize standard QHP and QDP designs for the following Plan Year.	Issuer	Yes	Yes	DVHA	Yes	October – January

Certification Criteria	Criteria Level (Issuer or QHP Product)	Initial Criteria?	Ongoing Certification Criteria?	State of Vermont Agency Responsible for Review	Apply to QDPs?	Timing Within Annual Timeline
Provide high-level proposal for new non-standard plans, or changes to existing non-standard plans other than uniform modifications for the following coverage year. To the extent allowed under the law, proposals will be treated as confidential at this phase.	Issuer	No	Yes	DVHA, DFR	No	January
File all product forms (summaries of benefits & coverage, contracts) for compliance review of EHB and VT-specific requirements, and actuarial value of non-standard plans (DVHA certifies the AV value of non-standard plans, which is submitted to DFR). Forms for additional plans or changes to existing non-standard plans may be submitted following GMCB approval but will not be approved until CGMCCB approval is received.	Product	Yes	Yes	DFR	Yes	Submission: March for standard and continuing non-standard plans April 15 for new or changed non-standard plans.

Certification Criteria	Criteria Level (Issuer or QHP Product)	Initial Criteria?	Ongoing Certification Criteria?	State of Vermont Agency Responsible for Review	Apply to QDPs?	Timing Within Annual Timeline
Make any changes/corrections to product forms as identified by DFR.	Product	Yes	Yes	DFR	Yes	Review finalized: June
Issuers present proposals for new non-standard plans for GMCB approval. Changes to existing non-standard plan designs that are uniform modifications, as defined by federal law and determined by DFR, do not require GMCB approval.	Product	Yes	Yes	GMCB: review and approve or deny	No	As scheduled by GMCB, no later than April 15
Submit a rate request for all anticipated products to be offered in the upcoming Plan Year with all required documentation.	Issuer	Yes	Yes	GMCB	Yes. Submit rates to DFR, not GMCB.	May
Complete SERFF binder files with all benefit, rate and other information including the Vermont Cost Sharing Reduction (VCSR) calculation as directed by DVHA.	Product and Issuer	Yes	Yes	DFR, DVHA	Yes, except CSR and VCSR do not apply.	June

Certification Criteria	Criteria Level (Issuer or QHP Product)	Initial Criteria?	Ongoing Certification Criteria?	State of Vermont Agency Responsible for Review	Apply to QDPs?	Timing Within Annual Timeline
Implement approved rates as ordered or approved by GMCB.	Product	Yes	Yes	GMCB	Yes, as ordered by DFR, not GMCB.	August
Complete plan certification for QHPs and Reflective silver plans offered on and off Exchange for the individual and Small Group markets. Provide formal notification to Issuers.	Issuer	Yes	Yes	DVHA	Yes	Sept. 1
Complete internal operational readiness and system coordination with the Exchange.	Issuer	Yes	Yes	DVHA	Yes	Beginning in July and Completed no later than October 15 (approximately two weeks in advance of AOEP)