Vermont Insurance Division

BULLETIN 122: Laws Enacted During the 1997-98 Legislative Session That Affect Insurers Doing Business in Vermont

August, 1998

Eleven laws were enacted in Vermont in 1998 that may affect insurers doing business in Vermont. Below are a list and short description of each Act. Where required, the Department will propose regulations or issue bulletins to further explain or define insurer and Department operations under these new laws. This bulletin is intended to provide general information and alert interested parties to changes that may be necessary in their operations. Any insurer or other party who may be affected by any of these laws is urged to get a copy of the Act from:

Legislative Council
115 State Street
Drawer 33
Montpelier, VT 05633-5301
(802) 828-2231

Or an unofficial version may be obtained from the Vermont Legislative Home

Page web site at: http://www.leg.state.vt.us/

ACT 65 (H.59) RELATING TO LETTER OF CREDIT: Letters of credit are commercial undertakings by a third party to a transaction to assure payment upon the occurrence of some future event. Letters of credit enable parties to a contract to finalize a sale or other transaction even though the parties to the contract are virtual strangers and geographically far apart. With letters of credit, for example, the seller of goods (the beneficiary) is assured payment by a financially sound entity upon completing performance, without regard to the buyer's financial condition. In addition, letters of credit can also be used to guarantee performance. In a performance situation, the beneficiary of the letter of credit demands payment of the issuer (a third party, usually a bank), if performance is inadequate. The bill substantially amends Article 5 of the Uniform Commercial Code (Title 9A V.S.A.) to incorporate the most up-to-date version of Article 5, bringing Vermont law current with other state laws on letters of credit. Uniform laws, such as Article 5 on Letters of Credit, bring predictability to commercial transactions essential to the smooth and efficient flow of commerce.

ACT 80 (H.209) RELATING TO CONTAMINATED SITES: The Act provides that, in specific situations, strict liability for contamination does not apply to a person, otherwise liable, who can establish that the release of hazardous materials was caused solely by the migration of a release of hazardous materials that did not originate on that person's property. The statute also establishes a pilot project, implemented by the Secretary of Natural Resources, which is available to no more than five applicants. Participation in the

pilot project provides relief from pollution liability for redevelopment of contaminated land under a corrective action plan approved by the Secretary.

ACT 95 (H.274) RELATING TO HEALTH INSURANCE AND CRANIOFACIAL DISORDERS. 8 V.S.A. 4089e.: This Act requires all health insurers to provide coverage for diagnosis and medically necessary treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. This coverage shall be the same as that provided under the health insurance plan for any other musculoskeletal disorder in the body and may be provided when prescribed or administered by a physician or dentist. However, a referral may be required from a Plan's participating health care provider. The coverage mandated by this law does not include dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge. The effective date of this mandate was July 1, 1998.

ACT 100 (H.582) RELATING TO THE CONVERSION OR MERGER OF STOCK OR MUTUAL INSURANCE COMPANIES WITH OR INTO RECIPROCAL INSURERS: This law proposes to increase the ability of existing captives to come to Vermont by providing them with the opportunity to either merge or convert into a Vermont reciprocal captive insurer. This bill also replaces language in the captive law that was inadvertently deleted last year.

ACT 109 (H.452) RELATING TO THE REGULATION OF SERVICE CONTRACT COMPANIES. The Act creates a regulatory framework for supervision of service contract companies. (Service contracts are a contractual promise of future services or replacement of personal property that is defective or fails. These products may be a form of insurance policy, but not always.) The law requires registration and places financial responsibility requirements on these companies. Further, it regulates the minimum standards for the contracts offered. The statute also specifies the remedies available to the Department and consumers for compliance.

ACT 110 (S.29) RELATING TO LANDOWNER LIABILITY FOR UNCOMPENSATED RECREATIONAL USE BY THE PUBLIC. This Act encourages owners to make their land and water available, without compensation, for recreational use by the public by establishing that the owner would not be liable for property damage or personal injury to individuals using their property for such recreational use unless the damage or injury is the result of willful or wanton misconduct of the owner.

ACT 112 (S.074) RELATING TO CANCELLATION OR NONRENEWAL OF HEALTH INSURANCE COVERAGE. 8 V.S.A. 4089e and 8 V.S.A. 4091c(c): This law provides that all carriers must notify a policyholder of any premium payment due on a policy at least 21 days before the due date. If payment is not received by the due date, a carrier must send a termination notice to the policyholder notifying the policyholder that termination of the policy will be effective on the due date if payment is not received within 14 days from the date of mailing of the termination notice.If payment is not

received within 14 days from the mailing date of the termination notice, coverage may be cancelled effective as of the due date. A carrier's notification to policyholders of payments due and termination may contain time lines that are more consumer friendly, but the carrier's notification cannot be more restrictive than this law. 8 V.S.A. 4091c(c), regarding group policies, was amended to reflect the provisions set forth in 4089e (above). This law became effective on July 1, 1998.

ACT 117 (S.185) RELATING TO DRIVING UNDER THE INFLUENCE (DUI). The Act increases Financial Responsibility limits from $20,000/40,000/10,000 to $25,000/50,000/10,000 and UM/UIM minimum limits from $20,000/40,000/10,000 to $50,000/100,000/10,000 for new and renewed policies. Where there is subrogation under UM/UIM coverage, the Act provides that any insured who has incurred expenses in recovering against any party is entitled to have a fair portion of the expenses of recovery deducted from the amount of subrogation. Under the new law, automobile liability insurers are required, within 30 days of a written request, to disclose to potential claimants the names of the insurer and the insured, and the limits of insurance coverage. For those convicted of DUI, the Act requires maintenance of automobile liability insurance with the statutory minimum limits, which shall be noncancellable except upon 15 days' prior notice to the Commissioner of Motor Vehicles.

ACT 128 (S.253) RELATING TO HEALTH INSURANCE COVERAGE FOR NUTRITIONAL TREATMENT FOR INHERITED METABOLIC DISEASES (PKU). 8 V.S.A. 4089d.: The Act requires that all carriers provide coverage for medical foods prescribed for the medically necessary treatment of an inherited metabolic disease. Coverage for low protein modified food products prescribed for medically necessary treatment of an inherited metabolic disease shall be at least $2,500 during any continuous period of twelve (12) months for an insured individual. The Health Department and the Department of Social Welfare, in consultation with health insurance carriers, shall create a system by which: (1) purchases of medical food are made at reduced prices and the medical food is provided at a price that reflects only the price paid for the formula and any related storage and handling costs incurred; and (2) outreach and education are provided to the public. This law took effect on April 27, 1998 and applies to all health insurance policies issued, offered, or renewed on and after October 1, 1998.

ACT 140 (H.704) RELATING TO REVIEW OF ATTORNEY FEES IN WORKERS' COMPENSATION CLAIMS: This act requires that the Commissioner of Labor and Industry review the amount awarded for attorney fees in workers' compensation cases by January 1,1999, and every five years thereafter.

ACT 159 (H.163) RELATING TO THE PUBLIC COUNSEL FOR HEALTH INSURANCE SEC. 1. INDEPENDENT EXTERNAL REVIEW OF HEALTH CARE SERVICE DECISIONS. 8 V.S.A.4089d:
Any insured under a health benefit plan who has exhausted all applicable internal review procedures provided by the plan shall have the right to an independent external review of a decision under the plan to deny, reduce, or terminate health care coverage or deny payment for a health care service. The independent review shall be available when

requested in writing by the affected insured, provided the decision to be reviewed requires the plan to expend at least $100.00 for the service and the decision by the plan is based on one of the following reasons: (1) the health careservice is a covered benefit that the health insurer has determined to be not medically necessary; (2) a limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and regulations; (3) the health care treatment has been determined to be experimental, investigational, or an off-label drug; or (4) the health care service involves a medically-based decision that a condition is pre-existing. The independent external review will be conducted by independent review organizations under contract with the Department. The cost of the review will be borne by the insurer, with the exception of a $25.00 filing fee to be paid by the insured (which may be waived or reduced by the Commissioner based on the financial circumstances of the insured). The Department will adopt rules to carry out the purposes of this law by July 1, 1999. The rules will ensure that the independent external reviews follow the guidelines set forth in the law and that the rights of the insured are protected. The Independent External Appeals Panel will not review the following, which have their own review processes already established: (1) mental health and substance abuse conditions; (2) health care services provided by the Vermont Medicaid program or Medicaid benefits provided through a contracted health plan; or (3) health care services provided to inmates by the Department of Corrections. This section of the law was effective April 29, 1998. The Department will promulgate rules by July 1, 1999 and the independent external review procedure will be fully implemented by October 1, 1999.

SEC. 2. OFFICE OF HEALTH CARE OMBUDSMAN. 8 V.S.A. 4089e and 8 V.S.A. 4089f: The Department will establish, through a contract with a non-profit corporation, the Office of Health Care Ombudsman. The office will be administered by the Health Care Ombudsman, an individual with expertise and experience in the fields of health care and advocacy. The Health Care Ombudsman will assist and advocate on behalf of health care consumers; provide education to consumers regarding health insurance choices; identify systemic issues regarding health insurance in Vermont and recommend solutions; and perform such other duties as required by law. The Department expects to award the contract in August, 1998 and the program will become operational shortly thereafter.

SEC. 3. DEFINITION OF INSURER. 8 V.S.A. 3681(5): This section of the law amends 8 V.S.A. 3681(5) to read: Insurer means a company qualified and licensed to transact the business of insurance in this state and shall include a health maintenance organization, except that it shall not include: (A) Agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state, (B) fraternal benefit societies, or (C) non-profit medical and hospital service associations. The effect of this amendment is to add health maintenance organizations to the definition of insurer as used in holding companies and subsidiaries. This section was effective on April 29, 1998.

SEC. 4. SOLVENCY PROTECTIONS. 8 V.S.A. 5102(b) This section provides that, if the Commissioner determines that the premiums-received by a health maintenance organization for its Vermont members exceeds $2,000,000 for any calendar year or that

the health maintenance organization was incorporated in a state without solvency protections that are substantially equivalent to those offered under this chapter, the Commissioner may order that Vermont contracts be conducted through an affiliate or subsidiary corporation incorporated under Vermont law. This section was effective on April 29, 1998.

SEC. 5. APPLICATION FOR CONTINUING AUTHORITY UPON MERGER, CONSOLIDATION, TRANSFER OR CONTROL, OR SALE OF CONTRACTS. 8 V.S.A. 5107a: This section relates to specific conditions under which a health maintenance organization must receive approval from the Commissioner before any merger, consolidation, transfer, or sale of Vermont contracts takes place. This section was effective on April 29, 1998.

SEC. 14A. PAYMENT FOR HEALTH CARE SERVICES. 18 V.S.A. 9418:This new law applies to health insurers, disability insurers, health maintenance organizations, medical or hospital service corporations, workers' compensation policies of casualty insurers licensed to do business in Vermont and any health plan that requires its medical groups, independent practice associations or other independent contractors to pay claims for the provision of health care services. The law provides specific time lines for the handling of claims by health plans. Health plans are required, within 45 days of receipt of a claim, to pay or reimburse the claim, or notify the claimant in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial of the claim and a description of any additional information required for the health plan to determine liability for the claim. If aclaim is contested due to insufficient information and written notice has been sent as stated above, the health plan has 45 days after receipt of the additional information to complete consideration of the claim. Interest, at a rate of 12 percent per annum, shall accrue on an unpaid claim after the expiration of the applicable review period. The effective date of this section was July 1, 1998.

ACT 160 (H.89) GENETIC TESTING: This Act prohibits the use of genetic testing as a condition of insurance coverage or employment; the term genetic testing is specifically defined in the Act. The law does not prohibit insurers (except those health insurers prohibited from medical underwriting under Vermont law) from continuing to use traditional medical tests which report on an individual's current medical condition provided such tests are not designed or intended to be specifically determinative for the presence or absence of a mutation, alteration, or deletion of a gene or chromosome. Insurers may require genetic testing where an individual is already suffering from a particular heritable disease or disorder, or is experiencing symptoms highly predictive of that disease or disorder. The law also allows insurers to use the results of genetic tests already in an individual's medical file where the insurer can demonstrate that the insurer's risk would increase by insuring that individual. The Commissioner is required to report every two years on the impact of genetic testing on the life, disability, and long-term care insurance markets.

FILING REQUIREMENTS FOR MEDICAL HEALTH PLANS. All future health filings must incorporate, where applicable, the services described in Acts 95, 112, and 128, and

sections 1 and 14 of Act 159. The filing must contain all required information including appropriate wording which clearly conveys the coverage for those services to enrolled members. Filings incorporating those services may be in the form of an endorsement to an existing contract or certificate, or may be in the form of a new contract or certificate. Filings must be received by the Department at least 60 days prior to their first intended use and cannot be used until approved by the Department. If the insurer's plans already comply with these laws, an informational filing will be sufficient. The Department requests that insurers submit these filings as soon as possible. The Department does not require that all mandates be addressed in one filing. Please do not delay submission for one mandate if form preparation for incorporation of another mandate is delayed. Note: The Statutory Revision Commission will correct for the fact that Acts 128 and 159 have assigned law to 8 V.S.A. 4089d and Acts 95, 112 and 159 have assigned law to 8 V.S.A. 4089e by renumbering those sections. The amended statutory citations will appear in the update to the Vermont Statutes Annotated.

Elizabeth R. Costle

COMMISSIONER