

**VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND
HEALTH CARE ADMINISTRATION**

RULE H-2006-01

CATAMOUNT HEALTH INSURANCE

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Section 1. Purpose

The purpose of this Rule is to set forth the requirements for Catamount Health insurance, as provided in 8 V.S.A. § 4080f and An Act Relating to Health Care Affordability for Vermonters, 2005 Vt. Acts & Resolves No. 191 (Adj. Sess. 2006). Catamount Health insurance shall be sold and administered in accordance with the Act and the policies and purposes of Title 8.

Section 2. Authority

This Rule is issued pursuant to the authority vested in the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration by the Act, including, but not limited to, 8 V.S.A. § 4080f, and by other applicable portions of Title 8, including, but not limited to, 8 V.S.A. § 4062.

Section 3. Definitions

As used in this Rule:

- (a) “Act” means An Act Relating to Health Care Affordability for Vermonters, 2005 Vt. Acts & Resolves No. 191 (Adj. Sess. 2006).
- (b) “Catamount Health insurance” means those health insurance products and plans approved by the Commissioner and established under 8 V.S.A. § 4080f, Act 191, Adj. Session (2006) and this Rule.
- (c) “Catamount Health carrier” or “carrier” means a carrier that sells, offers, issues or renews Catamount Health insurance as defined by § 4080f and this Rule. A carrier shall not sell Catamount Health unless the carrier is a registered small group carrier under 8 V.S.A. § 4080a.
- (d) “Chronic care” means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include, but are not limited to, diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.
- (e) “Chronic care management ” means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications, utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
- (f) “Commissioner” means the Commissioner of the Vermont Department of Banking, Insurance, Securities and Health Care Administration.
- (g) “Community rating” means a rating process that produces average rates for those individuals insured by Catamount Health insurance for a given policy period. Community rating as used in this Rule may allow for premium deviations among individuals based on incentives pursuant to rules adopted by the Commissioner under 8 V.S.A. §§ 4080a(h)(2)(B) and 4080b(h)(2)(B) relating to health promotion and disease prevention.

- (h) “Credibility” means a measure of the degree of statistical significance that can be assigned to the claims experience of a Catamount Health plan when it is used as a basis for projecting a future rate.
- (i) “Creditable coverage” includes coverage defined under applicable federal law as creditable including: a group health plan, such as one obtained through an employer or spouse’s employer; health insurance coverage, including individual coverage; Medicare and Medicaid, CHAMPUS/TriCare; a medical program of the Indian Health Service Act or of a tribal organization; a state health benefits high risk pool; the Federal Employees Health Benefits Program; a public health plan; and a health benefit plan under section 5(e) of the Peace Corps Act. Subject to federal law, the definition of creditable coverage includes any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer, which includes, but is not limited to, comprehensive nongroup, small group and large group policies.
- (j) “Health care professional” means an individual, partnership, corporation, facility (including a hospital) or institution licensed or certified or authorized by law to provide professional health care services.
- (k) “Health insurance trend factor” means a projection factor that is an estimate of the unit cost increases and utilization increases that are expected to be incurred in a health benefits plan. The estimate of unit cost increases and utilization increases may include consideration of erosion of deductibles, medical technology, general inflation and cost shifting.
- (l) “Network” means the network defined by the carrier in its Catamount Health policy. Catamount Health networks shall be created and managed consistent with the purposes of the Act and other applicable law.
- (m) “Preventive care” means health services provided by health care professionals to identify and treat asymptomatic individuals who have developed risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.
- (n) “Primary care” means health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and shall include prenatal care and the treatment of mental illness.
- (o) “Uninsured” means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur and had no creditable private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost

creditable private health insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

- (i) the individual's private insurance or employer-sponsored coverage ended because of:
 - (A) loss of employment;
 - (B) death of the principal insurance policyholder;
 - (C) divorce or dissolution of a civil union;
 - (D) no longer qualifying as a dependent under the plan of a parent or caretaker relative;
 - (E) no longer qualifying for COBRA, VIPER, or other state continuation coverage; or
- (ii) college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.
- (iii) "Uninsured individual" shall not include an individual who would be entitled to Catamount Health coverage without being uninsured for 12 months under 8 V.S.A. § 4080f(a)(9)(A) if the carrier determines, and the Commissioner gives prior approval to such determination, that such status was created primarily to obtain access to Catamount Health in a manner that is contrary to the intent of the Act. The Commissioner shall consult with appropriate legislative committees within 30 days following any such determinations.
- (iv) In order to be considered an "uninsured individual", a person shall be a Vermont resident and shall not be claimed as a dependent on a tax return by a person who is not a Vermont resident.

Section 4. Notice of Intent to Sell

A carrier intending to sell Catamount Health insurance shall submit a notice of intent to sell to the Commissioner no later than 30 days from the effective day of this Rule. Such letter shall identify the carrier and the anticipated dates the carrier intends to file for approval of Catamount Health rates and forms.

Section 5. Form Filings

- (a) Carriers shall file all Catamount Health forms for approval by the Commissioner prior to use.

- (b) Forms, as used in this Rule, shall include the following:
 - (i) all product forms, including but not limited to, policy forms, member handbooks, certificates, endorsements, riders, and applications;
 - (ii) materials intended to be publicly disseminated regarding chronic care management programs; and
 - (iii) materials intended to be publicly disseminated regarding wellness discount programs.
- (c) No form shall be approved if it contains any provision which is unjust, unfair, inequitable, misleading, contrary to the law of this state or otherwise fails to comply with the requirements of the Act or 8 V.S.A. § 4080f.
- (d) The carrier shall file for approval with the Commissioner the following documents prior to or contemporaneously with the filing of other forms under Section 5. The Commissioner shall approve such filings if in compliance with the goals of the Act and subject to such terms and conditions as he or she may prescribe.
 - (i) A chronic care management plan pursuant to Section 7 of this Rule.
 - (ii) A health care professional payment plan pursuant to Section 8 of this Rule.
 - (A) Health care professional payment plans shall be filed for approval when a Catamount Health carrier seeks to modify the methodology employed by the carrier to pay participating health care professionals. If amounts of the payment are the only modifications to the payment plan, no new filing is required.
 - (iii) A plan for determining eligibility pursuant to Section 10 of this Rule.
 - (iv) A cost containment plan consistent with the purposes of the Act.
- (e) The Commissioner shall notify the carrier within 45 days from receipt of the filing whether the submission is approved or denied.
- (f) Except as expressly provided to the contrary by this Rule, form filings shall be subject to the same rules and procedures applicable to other health insurance product filings.

Section 6. Benefit Design

- (a) Catamount Health benefit design, as reflected in a carrier's form filings, shall be approved by the Commissioner in accordance with the standards and procedures in 8 V.S.A. § 4080f, and other applicable law including 8 V.S.A. § 4062.
- (b) All Catamount Health insurance plans shall include coverage for primary care, preventive care, chronic care, acute episodic care and hospital services. Such coverage shall be provided consistent with the purposes of the Act.
- (c) The following out of pocket costs shall apply to Catamount Health policies. Catamount Health policies shall have:
 - (i) an annual deductible of \$250.00 for an individual and a \$500.00 deductible for a family for health services received in network, and a \$500.00 deductible for an individual and a \$1,000.00 deductible for a family for health services received out of network;
 - (A) A family deductible shall be satisfied when one insured, or a combination of insureds, satisfies the annual family deductible during the policy period.
 - (ii) 20% co-insurance for covered services received, other than office visits with a co-payment or prescription drugs, regardless of whether services are provided within or outside the carrier's network;
 - (iii) a \$10.00 office co-payment per individual, per visit;
 - (iv) prescription drug coverage with no deductible, however carriers may impose up to a \$10.00 co-payment for generic drugs, \$30.00 co-payment for drugs on the carrier's preferred drug list, and a \$50.00 co-payment for nonpreferred drugs;
 - (A) Prescription drug payments shall not count toward out of pocket maximums.
 - (v) annual out of pocket maximums shall be \$800.00 for an individual, \$1,600.00 for a family for in-network services and \$1,500.00 for an individual and \$3,000.00 for a family for out-of-network services.
 - (A) A family out pocket maximum shall be satisfied when one insured, or a combination of insureds, satisfies the annual family out of pocket maximum during the policy period.
- (d) Carriers shall waive deductibles and other cost-sharing payments for chronic care if the individual is actively participating in a chronic care management program.

- (e) Carriers shall waive deductibles and other cost-sharing payments for preventive care, provided such services are obtained in network. However, if preventive care services are not available in network, the carrier shall waive deductibles and other cost-sharing payments for preventive care services obtained outside of network.
- (f) Preexisting Condition Limitation
 - (i) A Catamount Health carrier may limit coverage of a preexisting condition which existed during the 12-month period before the effective date of coverage, except that such exclusion or limitation shall not apply to chronic care provided such individual is participating in a chronic care management program.
 - (A) Participation in a chronic care management program shall mean that the individual has enrolled or has indicated a willingness to become enrolled in a chronic care management program and is in substantial compliance with the requirements of the program.
 - (1) For the purposes of this subsection, if an individual has indicated a willingness to become enrolled in a chronic care management program, a carrier may place reasonable time limits for the insured to become enrolled in the program. If the insured fails to meet these time limits, the carrier shall not be required to waive the preexisting condition limitation. In no event shall the carrier require the individual become enrolled in the chronic care management program in less than 15 business days.
 - (B) A Catamount Health carrier shall offer a chronic care management program to an insured if such a program is generally available to the carrier's other insureds (whether through Catamount Health or otherwise) with the same chronic condition.
 - (C) Consistent with other applicable state and federal laws, qualifying participation in a chronic care management program shall not be premised on an individual achieving a specified health status, but it may be premised on specific participation obligations. If an individual's health reasonably prevents specified participation, a carrier shall make reasonable alternative accommodations or credit the insured with participation in the chronic care management program.
 - (ii) A carrier shall waive any preexisting condition provisions for all individuals and their covered dependents who produce evidence of

continuous creditable coverage during the previous nine months. The carrier shall credit coverage that occurred without a break in coverage of 63 days or more.

- (iii) For an “eligible individual”, as that term is defined by Section 2741 of Title XXVII of the Public Health Service Act, as amended if amended, a carrier offering Catamount Health shall not limit coverage of a preexisting condition.

Section 7. Chronic Care Management

- (a) Catamount Health carriers shall provide insureds access to chronic care management programs. Such programs shall be subject to approval by the Commissioner. Chronic care management programs shall be consistent with the purposes of the Act, including the use of criteria substantially similar to the chronic care management program established under 18 V.S.A. § 702 and 33 V.S.A. § 1903a, as amended.
- (b) As directed by the Commissioner, Catamount Health carriers shall share data about their chronic care management programs, to the extent allowable by federal and state law, with the Vermont Secretary of Administration or designee in order to support health care reform initiatives under 3 V.S.A. § 2222a and related legislation.

Section 8. Health Care Professional Relationships

- (a) Consistent with 8 V.S.A. § 4080f, benefits shall be delivered through a preferred provider organization (“PPO”) plan. Catamount Health carriers shall define their PPO within the parameters of commonly accepted industry practices, but such definition shall be consistent with the purposes of the Act.
- (b) Subject to subsection (i) below, Catamount Health products may not limit the type of licensed health care professional offering a covered benefit, so long as that health care professional is operating within the scope of his or her practice authorized by law.
 - (i) Catamount Health products may impose a greater financial burden on an individual’s access to treatment by the type of health care professional only if it is related to the efficacy or cost effectiveness of the services, subject to the approval of the Commissioner. As appropriate, the Commissioner may consult with the Vermont Department of Health to establish whether limits are appropriately premised on the efficacy and cost effectiveness of the services.

- (ii) Catamount Health carriers may impose credentialing criteria, consistent with the Act, on all participating health care professionals to ensure that minimum quality standards are met.
- (c) Health care professional payments for care shall be made consistent with the Act. The carriers shall file a health care professional payment plan consistent with the provisions of this section, and subject to approval of the Commissioner under Section 5.
 - (i) Catamount Health carriers shall negotiate payment agreements with health care professionals that are consistent with the Act.
 - (ii) If Catamount Health carriers and health care professionals cannot agree on a payment agreement, the Commissioner shall prescribe the provisions of the agreement in dispute.
 - (iii) Nothing in this subsection shall be construed to mean that carriers or the Department may mandate health care professionals participate in Catamount Health.
- (d) If Medicare does not pay for a service covered by a Catamount Health carrier, the carrier and health care professional shall negotiate a payment rate, subject to the approval or order of the Commissioner at his or her discretion.
- (e) Health care professional payment shall be consistent with chronic care management principles, including, but not limited to, those developed under 18 V.S.A. § 702 and 33 V.S.A. § 1903a.
- (f) A health care professional participating in a carrier's Catamount Health network that treats a Catamount Health insured shall not balance bill the insured.
 - (i) "Balance bill" as used above means to charge to or collect from a Catamount Health insured any amount in excess of the charge agreed to for services provided to Catamount Health insureds by the Catamount Health carrier and the health care professional providing the service.

Section 9. Wellness Programs

A Catamount Health carrier may use financial or other incentives to encourage healthy lifestyles and patient self-management, in accordance with programs of health promotion and disease prevention established under rules adopted by the Commissioner pursuant to 8 V.S.A. §§ 4080a(h)(2)(B) and 4080b(h)(2)(B).

Section 10. Eligibility Determination

- (a) Catamount Health insurance shall be offered, issued and renewed to all eligible individuals as defined by applicable law, including the Act and 8 V.S.A. § 4080f. After consultation with the Agency of Human Services with respect to an eligibility screening mechanism, carriers shall file a plan for determining eligibility consistent with the provisions of the this section, and subject to approval of the Commissioner under Section 5. Catamount Health carriers shall process Catamount Health applications within 30 business days from the date the application is completed.
 - (i) A carrier shall guarantee acceptance of any uninsured individual for any Catamount Health plan offered by the carrier. A carrier shall guarantee acceptance of each dependent of an uninsured individual in Catamount Health.
 - (A) A carrier shall not provide Catamount Health coverage for an individual of the age of majority who is claimed on a tax return as a dependent of a resident of another state.
 - (ii) Subject to subdivision (A) below, a carrier shall not sell Catamount Health to an individual who has access to employer-sponsored insurance through his or her employer.
 - (A) A carrier shall guarantee acceptance to an uninsured individual who has access to employer-sponsored insurance if the individual has an income under 300% of the federal poverty level and:
 - (1) the individual's employer-sponsored health insurance plan is not an approved plan under 33 V.S.A. § 1974;
 - (2) pursuant to 33 V.S.A. § 1974, the Agency of Human Services has determined that enrolling the individual in Catamount Health with premium assistance is more cost effective for the State of Vermont than enrolling the individual in employer-sponsored insurance; or
 - (3) the individual is eligible for employer-sponsored insurance premium assistance under 33 V.S.A. § 1974, but is unable to enroll in the employer's insurance plan until the next enrollment period.
 - (iii) An individual who loses eligibility for the employer-sponsored premium assistance under 33 V.S.A. § 1974 shall be allowed to purchase Catamount Health without being uninsured for 12 months.
 - (iv) For the purposes of this subsection, Catamount Health carriers shall accept proof of agency determinations when made under Title 33 relevant to

eligibility as prescribed by the agency responsible for making such decisions.

- (v) Catamount Health carriers and their producers shall inform each potentially eligible individual inquiring about purchasing health insurance in the nongroup market about the availability of Catamount Health and the existence of premium assistance programs.
- (b) Catamount Health carriers shall follow those procedures in 8 V.S.A. § 4089h (including any subsequent amendments) for nonpayment of premium. However, to the extent an insured is receiving premium assistance for Catamount Health through a state or federal agency, the carrier shall follow any guidance, bulletins or rules provided by the agency providing premium assistance, to the extent any such guidance, bulletins or rules exist. As directed by the Commissioner, carriers shall give notice of nonpayment of premium and premium increases to the appropriate governmental agency.
- (c) To the extent an individual is receiving or applying for Catamount Health premium assistance, carriers shall comply with, as determined by the Commissioner, any guidance, bulletins or rules issued by the governmental entity responsible for, or providing, premium assistance. In addition, Catamount Health carriers shall provide, to the extent allowed by law and as determined by the Commissioner, any information needed by the governmental entity to administer such premium assistance programs.
- (d) Individuals who believe they are eligible for Catamount Health, but have been denied coverage, may file a complaint with the Department of Banking, Insurance, Securities and Health Care Administration. The carrier shall notify the applicant at the time of the denial of his or her rights to file a written complaint with the Department. The carrier's appeal notice shall be on a form acceptable to the Commissioner. The Department shall provide written notice of the complaint to the carrier. If an informal resolution between the Department and the carrier cannot be reached within five business days of notice to the carrier, the carrier shall have ten days from the date the notice of the complaint was sent to file a written response. The Commissioner shall rule on the eligibility issue after receipt of the carrier's response, provided a response is timely filed. If the Commissioner rules the individual and dependents are eligible for coverage, such coverage shall become effective retroactive to the date the carrier received the completed application. The carrier or the applicant may appeal an adverse decision by the Commissioner under this subsection pursuant to Rule 82-1 (Revised). Coverage shall remain in effect while an appeal is pending.

Section 11. Pay-for-Performance Demonstration Project

Upon petition by a carrier, or as required by the Commissioner, the Commissioner may establish a pay-for-performance demonstration project for Catamount Health insurance.

Section 12. Premium Rates

- (a) Catamount Health premium rates shall be approved by the Commissioner prior to implementation. No rate shall be approved if it is unjust, unfair, inequitable, misleading or contrary to the law of this state. A rate shall be approved if it is sufficient not to threaten the financial safety and soundness of the insurer, reflects efficient and economical management, provides Catamount Health at the most reasonable price consistent with actuarial review, is not unfairly discriminatory, and complies with the other requirements of 8 V.S.A. § 4089f and the Act.
- (b) Initial proposed Catamount Health rates shall be filed no later than five months after the carrier files its letter of intent to sell.
- (c) Catamount Health premium rates shall be actuarially determined considering differences in the demographics of the populations and the different levels and methods of payment for health care professionals.
- (d) After the initial rate filing referenced in subsection (b) above, Catamount Health carriers shall file for rate approval at least 100 days prior to the proposed implementation of the rates being filed for approval. The Commissioner shall rule on a rate filing within 45 days of receipt. If a rate filing is denied, written request for a hearing may be filed within 30 days of the notice of disapproval.
 - (i) Rate filings shall include a certification by a member of the American Academy of Actuaries which certifies a carrier's compliance with this section and the Act. Such certification shall include sufficient detail for the Commissioner to verify that such certification is appropriate. Carriers shall provide additional information as requested by the Commissioner in order to verify representations in the rate filing.
 - (ii) The following statements by a member of the American Academy of Actuaries shall be included with each filing:
 - (A) the rates and proposed rating methodology meet the requirements of this Rule and 8 V.S.A. § 4080f; and
 - (B) the rates are reasonable in relation to the benefits provided, and they are neither excessive, deficient, nor unfairly discriminatory.
 - (iii) Rate filings shall include, at a minimum, the following:
 - (A) a description of the base claims experience data;

- (B) actuarial support for the health insurance trend factor used to project the base claims experience data forward to the rating period and a copy of the data used to calculate the trend factors;
 - (C) a description of each element of retention;
 - (D) a description of all other adjustments or elements included in or used to calculate the rates;
 - (E) an identification of the effective date that the rates were designed for and the effective period of the rates. For example: “These rates have been designed to apply to [the carrier’s Catamount Health plan], renewing on or after xx/xx/xx and will remain in effect for twelve months following renewal”;
 - (F) an explanation of adverse selection factors considered by the carrier.
- (e) Notice of a premium rate increase shall be provided to insureds at least 45 days prior to implementation, subject to waiver as approved by the Commissioner. In no event shall rate increases be implemented without at least 30 days written notice to the insured.
- (i) In the event rate increase notices cannot be provided in a timely manner as defined by this section, the carrier shall extend existing rates at least until applicable notice periods have been satisfied. Existing rates extended under this subsection shall continue in one month intervals until new rates are approved.
- (f) To be considered acceptable to the Commissioner, the rates submitted by a Catamount Health carrier shall be effective for at least a twelve-month policy period.
- (i) Subject to approval by the Commissioner, premium rates shall be submitted at least for “single”, “two-person” and “family” (more than two persons) classifications.
- (g) Catamount Health products shall be community rated. All of a carrier’s Catamount Health products shall have the same premium rate, subject to the classifications referred to in Section 12(f)(i) above, differing benefit levels and to the wellness or healthy discounts authorized by the Act, this Rule and any subsequent applicable law.
- (i) Medical underwriting and screening to exclude or individually rate a Catamount insured is not allowed. Catamount Health shall be rated as a single group. Catamount Health carriers shall not use rating plans which

contain any provisions for adjustments that are based upon medical underwriting or medical screening.

- (ii) Proposed community rates should be based upon reasonable projections of Catamount Health experience that has been incurred or is anticipated to be incurred. To the extent that the carrier's Catamount Health claims experience is not deemed to be fully credible, it can be combined with the carrier's other Vermont experience as deemed appropriate by the Commissioner.

Projections of the base claims experience forward to the period for which the proposed community rates are designed to be effective should be accomplished with the use of an appropriate health insurance trend factor.

- (iii) In addition to the expected claims cost, the carrier's community rates may contain appropriate allowances for administrative expenses, taxes, profit (in the case of for-profit carriers) or contribution to reserves (in the case of a nonprofit entity) and the cost of reinsurance, if any, and other elements used by the carrier as approved by the Commissioner.
 - (iv) The approved premium rates for the Catamount Health product shall not be adjusted for demographics (including age or gender), geographic area, industry, medical underwriting or screening, experience rating, tier rating or durational rating. Credit for healthy lifestyle or wellness program discounts are allowed and shall be shown in the rate filing.
- (h) If a carrier discontinues sales of the Catamount Health product pursuant to 8 V.S.A. § 4080f(n), the carrier shall continue to file for rate approval subject to this Rule for those lives that continue to be covered under existing policies. However, if a carrier does not file for rate approval, the Commissioner shall establish the appropriate premium rates in accordance with the statute.