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March 8, 2024

To: Senate Health and Welfare Committee

Re: S.151 - An act relating to pay parity and transparency in health care

From: The Office of the Health Care Advocate (HCA)

Dear Chair Lyons and Members of the Senate Committee on Health and Welfare:

The Office of the Health Care Advocate (HCA) believes there are three policy areas in S.151 version 2.1 that are important to move forward this year:

- language regarding consent to preventative services and treatment by minors,
- language regarding GMC Board membership, nomination, and appointment process,
- and the language updating workers compensation rates in Sec. 10 of the bill.

The remainder of the bill is either being addressed in bills that are moving this year, are problematic or not needed in the HCA's opinion.

If the committee chooses to move forward with intent language regarding AHEAD, the HCA suggests replacing the final paragraph with the following.

> It is the intent of the General Assembly that if the Administration, the Green Mountain Care Board and the federal Centers for Medicare and Medicaid Innovation come to an agreement on the AHEAD model and the state approves that agreement, the Green Mountain Care Board shall convene interested stakeholders to consider how to appropriately regulate hospital budgets in the context of the AHEAD global budgets. If the Board determines that statutory changes are needed, the GMCB shall propose these changes to the General Assembly in a timely manner for implementation.

The purpose of this edit is to clearly communicate the committee's position that it is the GMCB's responsibility to manage hospital budgets and therefore their job to determine how to reasonably regulate both an AHEAD Global Budget and a hospital budget for a given hospital.

The HCA also would like to recommend that the Committee consider including several sections of S.211 in S.151 2.1:

1) **Support the concept articulated in Sec. 8d and Sec. 12a to establish the Board's right to deliberate privately on ACO and hospital budget processes. We believe this would improve the process. If the Committee has an interest in this, the Board should be consulted on the final language.**

2) **Support an amended version of Sec. 6(b)(1)(B),** which would read: "The Board may utilize reference-based pricing, site-neutral payments, and other strategies that promote equitable reimbursement and the quality of, access to, and affordability of health care services in this State."

3) **Support the inclusion of a part of Sec. 8(f) of S.211**, which reads: "(f) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying ACOs that receive payments only from Medicare. In determining whether to certify an Medicare-only ACO to operate in this State, the Board may consider as many of the criteria described in subsection (a) of this section as the Board deems appropriate to a specific ACO's size and scope. Currently, the Board is highly constrained in its ability to regulate Medicare-only ACOs in the state. This provision would permit the Board to adopt rules to regulate in this rapidly growing area of the health care system in Vermont.

4) **Support Sec. 17,** which reads: "The Office of the Attorney General, in collaboration with the Green Mountain Care Board, shall develop joint legislative proposals for appropriate review and approval of mergers, affiliations, and divestments involving hospitals, clinics, independent practices, long-term care facilities, and other health care providers located in Vermont by the Office of the Attorney General or the Green Mountain Care Board, or both. On or before December 15, 2024, the Office of the Attorney General and the Green Mountain Care Board shall provide their legislative proposals to the House Committees on Health Care and on Human Services, the Senate Committee on Health and Welfare, and the Health Reform Oversight Committee."

As proposed in committee, the HCA also requests the following amendment to clarify our office's right to ask questions in the insurance Rate Review process. It is essential that the state's consumer advocate is not constrained in its ability to ask questions of the insurers in the rate review process.

8 V.S.A. § 4062

§ 4062. Filing and approval of policy forms and premiums

* * *

(c)(1) The Board shall provide information to the public on the Board's website about the public availability of the filings and summaries required under this section.

(2)(A) The Board shall post the rate filings pursuant to subsection (a) of this section and summaries pursuant to subsection (b) of this section on the Board's website within five calendar days following filing. The Board shall also establish a mechanism by which members of the public may request to be notified automatically each time a proposed rate is filed with the Board.

(B) The Board shall provide an electronic mechanism for the public to comment on all rate filings. The Board shall accept public comment on each rate filing from the date on which the Board posts the rate filing on its website pursuant to subdivision (A) of this subdivision (2) until 15 calendar days after the Board posts on its website the analyses and opinions of the Department of Financial Regulation and of the Board's consulting actuary, if any, as required by subsection (d) of this section. The Board shall review and consider the public comments prior to issuing its decision.

(3)(A) In addition to the public comment provisions set forth in this subsection, the Office of the Health Care Advocate established in 18 V.S.A. chapter 229, acting on behalf of health insurance consumers in this State, may, within 30 calendar days after the Board receives an insurer's rate request pursuant to this section, submit to the Board, in writing, ~~suggested~~ questions regarding the filing ~~for~~ which the Board ~~to~~ shall ask the insurer, either directly or through its ~~provide to~~ contracting actuary, if any.

(B) The Office of the Health Care Advocate may also submit to the Board written comments on an insurer's rate request. The Board shall post the comments on its website and shall consider the comments prior to issuing its decision.

(d)(1) The Board shall contemporaneously post on its website or otherwise make available to the public via a filesharing platform, after redacting any confidential or proprietary information relating to the insurer or to the insurer's rate filing, all materials in the record of a rate review proceeding. The record shall consist of:

(A) the entire SERFF filing submitted by the insurer, including any amendments;

(B) all questions posed by the Board to its consulting actuary and the actuary's responses, if any;

(C) all questions posed by the Board, the Board's consulting actuary, or the Department to the insurer and the insurer's responses, if any;

(D) the Department's written analysis and opinion of the effect of the proposed rate on the insurer's solvency;
(E) the analysis and opinion of the Board's consulting actuary;
(F) any pleadings, motions, or written materials submitted by a Party to include the insurer and after entering an appearance, the Office of the Health Care Advocate;
(G) any intermediate rulings by the Board;
(H) evidence submitted by the Parties, including testimony;
(I) a statement of matters officially noticed;
(J) questions and offers of proof, objections, and rulings thereon;
(K) proposed findings and objections, if any; and
(L) the decision of the Board.

~~No later than 60 calendar days after receiving an insurer's rate request pursuant to this section, the Green Mountain Care Board shall make available to the public the insurer's rate filing, the Department's analysis and opinion of the effect of the proposed rate on the insurer's solvency, and the analysis and opinion of the rate filing by the Board's contracting actuary, if any.~~

(2) The public record shall exclude any information that is determined by the Board to be confidential or is otherwise subject to protection to disclosure by law.

~~The Board shall post on its website, after redacting any confidential or proprietary information relating to the insurer or to the insurer's rate filing:~~

~~(A) all questions the Board poses to its contracting actuary, if any, and the actuary's responses to the Board's questions; and~~

~~(B) all questions the Board, the Board's contracting actuary, if any, or the Department poses to the insurer and the insurer's responses to those questions.~~

* * *

Thank you for your consideration and continued leadership in this important area.

Sincerely,

s\ Mike Fisher, Chief Health Care Advocate

s\ Sam Peisch, Health Policy Analyst