

1 S.200

2 Introduced by Senators Pollina, Doyle and Illuzzi

3 Referred to Committee on Health and Welfare

4 Date: January 3, 2012

5 Subject: Health; health insurance disclosures; VHCURES

6 Statement of purpose: This bill proposes to expand health insurers' reporting
7 obligations in their annual reports and under the Vermont healthcare claims
8 uniform reporting and evaluation system (VHCURES).

9 An act relating to the reporting requirements of health insurers

10 It is hereby enacted by the General Assembly of the State of Vermont:

11 ~~Sec. 1. 8 V.S.A. § 3561(a) is amended to read:~~

12 ~~(a)(1) Each domestic, foreign, and alien insurance company doing business~~
13 ~~in this state shall annually submit to the commissioner a statement of its~~
14 ~~financial condition, verified by oath of two of its executive officers. The~~
15 ~~statement shall be prepared in accordance with the National Association of~~
16 ~~Insurance Commissioners' Instructions Handbook and Accounting Practices~~
17 ~~and Procedures Manual and shall be in such general form and context, as~~
18 ~~approved by, and shall contain any other information required by, the National~~
19 ~~Association of Insurance Commissioners with any useful or necessary~~
20 ~~modifications or adaptations thereof required or approved or accepted by the~~

1 ~~commissioner for the type of insurance and kinds of insurers to be reported~~
2 upon, and as supplemented by additional information required by the
3 commissioner.

4 (2)(A) In addition, a health insurance company shall provide the
5 following information, in plain language:

6 (i) the salaries, bonuses, and compensatory benefits of all
7 corporate officers and board members during the preceding fiscal year;

8 (ii) the health insurance company's marketing and advertising
9 expenses during the preceding fiscal year;

10 (iii) the health insurance company's travel expenses during the
11 preceding fiscal year;

12 (iv) the health insurance company's federal and state lobbying
13 expenses during the preceding fiscal year;

14 (v) the amount and recipient of each political contribution made
15 by the health insurance company during the preceding fiscal year;

16 (vi) the amount and recipient of dues paid during the preceding
17 fiscal year by the health insurance company to trade groups engaged in
18 lobbying efforts or that make political contributions;

19 (vii) the health insurance company's legal and consultation
20 expenses during the preceding fiscal year;

1 ~~(viii) the health insurance company's occupancy related expenses~~
2 during the preceding fiscal year;

3 (ix) the amount and recipient of charitable contributions made by
4 the health insurance company during the preceding fiscal year;

5 (x) a description of any changes the health insurance company has
6 made during the preceding fiscal year regarding its health care
7 cost-containment and quality improvement efforts; and

8 (xi) where possible, how the health insurance company's expenses
9 described in this subsection were allocated on a per-member per-month basis
10 for each of the benefit plans during the preceding fiscal year subject to state
11 review reporting requirements.

12 (B) The department of banking, insurance, securities, and health care
13 administration shall post the information pertaining to health insurance
14 companies described in subdivision (2)(A) of this subsection on its website.

15 (3) The statement of an alien insurer shall relate only to the insurer's
16 transactions and affairs in the United States unless the commissioner requires
17 otherwise.

18 (4) A foreign or alien company, upon withdrawing from the state of
19 Vermont shall pay to the commissioner \$25.00 for the filing of its final
20 financial statement.

1 ~~Sec. 2. 8 V.S.A. § 4516 is amended to read:~~

2 § 4516. ANNUAL REPORT TO COMMISSIONER

3 (a) Annually, on or before March 15, a hospital service corporation shall
4 file with the commissioner of banking, insurance, securities, and health care
5 administration a statement sworn to by the president and treasurer of the
6 corporation showing its condition on December 31. The statement shall be in
7 such form and contain such matters as the commissioner shall prescribe,
8 including, in plain language:

9 (1) the salaries, bonuses, and compensatory benefits of all corporate
10 officers and board members during the preceding fiscal year;

11 (2) the hospital service corporation's marketing and advertising
12 expenses during the preceding fiscal year;

13 (3) the hospital service corporation's travel expenses during the
14 preceding fiscal year;

15 (4) the hospital service corporation's federal and state lobbying
16 expenses during the preceding fiscal year;

17 (5) the amount and recipient of each political contribution made by the
18 hospital service corporation during the preceding fiscal year;

19 (6) the amount and recipient of dues paid during the preceding fiscal
20 year by the hospital service corporation to trade groups engaged in lobbying
21 efforts or that make political contributions;

1 ~~(7) the hospital service corporation's legal and consultation expenses~~
2 ~~during the preceding fiscal year;~~

3 ~~(8) the hospital service corporation's occupancy-related expenses during~~
4 ~~the preceding fiscal year;~~

5 ~~(9) the amount and recipient of charitable contributions made by the~~
6 ~~hospital service corporation during the preceding fiscal year;~~

7 ~~(10) a description of any changes the hospital service corporation has~~
8 ~~made during the preceding fiscal year regarding its health care~~
9 ~~cost-containment and quality improvement efforts; and~~

10 ~~(11) where possible, how the expenses described in this subsection were~~
11 ~~allocated on a per-member per-month basis for each of the benefit plans during~~
12 ~~the preceding fiscal year subject to state review reporting requirements.~~

13 ~~(b) The department of banking, insurance, securities, and health care~~
14 ~~administration shall post the information described in subsection (a) of this~~
15 ~~section on its website.~~

16 ~~(c) To qualify for the tax exemption set forth in section 4518 of this title,~~
17 ~~the statement shall include a certification that the hospital service corporation~~
18 ~~operates on a nonprofit basis for the purpose of providing an adequate hospital~~
19 ~~service plan to individuals of the state, both groups and nongroups, without~~
20 ~~discrimination based on age, gender, geographic area, industry, and medical~~

1 ~~history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B)~~
2 of this title.

3 Sec. 3. 8 V.S.A. § 4588 is amended to read:

4 § 4588. ANNUAL REPORT TO COMMISSIONER

5 Annually, on or before March 15, a medical service corporation shall file
6 with the commissioner of banking, insurance, securities, and health care
7 administration a statement sworn to by the president and treasurer of the
8 corporation showing its condition on December 31, which shall be in such
9 form and contain such matters as the commissioner shall prescribe, including,
10 in plain language:

11 (1) the salaries, bonuses, and compensatory benefits of all corporate
12 officers and board members during the preceding fiscal year;

13 (2) the medical service corporation's marketing and advertising
14 expenses during the preceding fiscal year;

15 (3) the medical service corporation's travel expenses during the
16 preceding fiscal year;

17 (4) the medical service corporation's federal and state lobbying
18 expenses during the preceding fiscal year;

19 (5) the amount and recipient of each political contribution made by the
20 medical service corporation during the preceding fiscal year;

1 ~~(6) the amount and recipient of dues paid during the preceding fiscal~~
2 ~~year by the medical service corporation to trade groups engaged in lobbying~~
3 ~~efforts or that make political contributions;~~

4 ~~(7) the medical service corporation's legal and consultation expenses~~
5 ~~during the preceding fiscal year;~~

6 ~~(8) the medical service corporation's occupancy-related expenses during~~
7 ~~the preceding fiscal year;~~

8 ~~(9) the amount and recipient of charitable contributions made by the~~
9 ~~medical service corporation during the preceding fiscal year;~~

10 ~~(10) a description of any changes the medical service corporation has~~
11 ~~made during the preceding fiscal year regarding its health care~~
12 ~~cost-containment and quality improvement efforts; and~~

13 ~~(11) where possible, how the expenses described in this subsection were~~
14 ~~allocated on a per-member per-month basis for each of the benefit plans during~~
15 ~~the preceding fiscal year subject to state review reporting requirements.~~

16 ~~(b) The department of banking, insurance, securities, and health care~~
17 ~~administration shall post the information described in subsection (a) of this~~
18 ~~section on its website.~~

19 ~~(c) To qualify for the tax exemption set forth in section 4590 of this title,~~
20 ~~the statement shall include a certification that the medical service corporation~~
21 ~~operates on a nonprofit basis for the purpose of providing an adequate medical~~

1 ~~service plan to individuals of the state, both groups and nongroups, without~~
2 discrimination based on age, gender, geographic area, industry, and medical
3 history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B)
4 of this title.

5 Sec. 4. 8 V.S.A. § 5106(a) is amended to read:

6 (a)(1) Every organization subject to this chapter, annually, within 120 days
7 of the close of its fiscal year, shall file a report with the commissioner, said
8 report verified by an appropriate official of the organization, showing its
9 financial condition on the last day of the preceding fiscal year. The report shall
10 be prepared in accordance with the National Association of Insurance
11 Commissioners' Accounting Practices and Procedures Manual for health
12 maintenance organizations and shall be in such general form and context, as
13 approved by, and shall contain any other information required by the National
14 Association of Insurance Commissioners together with any useful or necessary
15 modifications or adaptations thereof required, approved or accepted by the
16 commissioner for the type of organization to be reported upon, and as
17 supplemented by additional information required by the commissioner,
18 including, in plain language:

19 (A) the salaries, bonuses, and compensatory benefits of all corporate
20 officers and board members during the preceding fiscal year;

1 ~~(B) the organization's marketing and advertising expenses during the~~
2 ~~preceding fiscal year;~~

3 ~~(C) the organization's travel expenses during the preceding fiscal~~
4 ~~year;~~

5 ~~(D) the organization's federal and state lobbying expenses during the~~
6 ~~preceding fiscal year;~~

7 ~~(E) the amount and recipient of each political contribution made by~~
8 ~~the organization during the preceding fiscal year;~~

9 ~~(F) the amount and recipient of dues paid during the preceding fiscal~~
10 ~~year by the organization to trade groups engaged in lobbying efforts or that~~
11 ~~make political contributions;~~

12 ~~(G) the organization's legal and consultation expenses during the~~
13 ~~preceding fiscal year;~~

14 ~~(H) the organization's occupancy-related expenses during the~~
15 ~~preceding fiscal year;~~

16 ~~(I) the amount and recipient of charitable contributions made by the~~
17 ~~organization in the preceding fiscal year;~~

18 ~~(J) a description of any changes the organization has made during the~~
19 ~~preceding fiscal year regarding its health care cost-containment and quality~~
20 ~~improvement efforts; and~~

1 ~~(K) where possible, how the expenses described in this subsection~~
2 ~~were allocated on a per-member per-month basis for each of the benefit plans~~
3 ~~during the preceding fiscal year subject to state review reporting requirements.~~

4 (2) The department of banking, insurance, securities, and health care
5 administration shall post the information described in subdivision (a)(1) of this
6 section on its website.

7 Sec. 5. 18 V.S.A. § 9410(h)(1) is amended to read:

8 (h)(1) All health insurers shall electronically provide to the commissioner
9 in accordance with standards and procedures adopted by the commissioner by
10 rule:

11 (A) their health insurance claims data, including paid and denied
12 claims, as well as appeals that result from denied claims, provided that the
13 commissioner may exempt from all or a portion of the filing requirements of
14 this subsection data reflecting utilization and costs for services provided in this
15 state to residents of other states;

16 * * *

17 Sec. 6. EFFECTIVE DATE

18 ~~This act shall take effect on July 1, 2012.~~

Sec. 1. 8 V.S.A. § 3561(a) is amended to read:

(a)(1) Each domestic, foreign, and alien insurance company doing business in this state shall annually submit to the commissioner a statement of its financial condition, verified by oath of two of its executive officers. The statement shall be prepared in accordance with the National Association of Insurance Commissioners' Instructions Handbook and Accounting Practices

and Procedures Manual and shall be in such general form and context, as approved by, and shall contain any other information required by, the National Association of Insurance Commissioners with any useful or necessary modifications or adaptations thereof required or approved or accepted by the commissioner for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the commissioner.

(2)(A) In addition, a health insurance company with a minimum of 200 Vermont lives covered in the relevant reporting year or which offers a plan in the Vermont health benefit exchange pursuant to 33 V.S.A. § 1803 shall provide the following information:

(i) the total number of claims submitted to the health insurance company;

(ii) the total number of denials of service by the health insurance company at the preauthorization level, including:

(I) the total number of denials of service at the preauthorization level appealed to the health insurance company at the first level grievance;

(II) the total number of denials of service at the preauthorization level overturned at the first level grievance;

(III) the total number of denials of service at the preauthorization level appealed to the health insurance company at any second level grievance;

(IV) the total number of denials of service at the preauthorization level overturned at any second level grievance; and

(V) the total number of denials of service at the preauthorization level for which external review is sought and the number overturned by external review;

(iii) the total number of service claims denied by the health insurance company, including:

(I) the total number of denied service claims appealed to the health insurance company at the first level grievance;

(II) the total number of denied service claims overturned at the first level grievance;

(III) the total number of denied service claims appealed to the health insurance company at any second level grievance;

(IV) the total number of denied service claims overturned at any second level grievance; and

(V) the total number of denied service claims for which external review is sought and the number overturned by external review; and

(iv) the total number of claims denied by a health insurance company for reasons not related to network issue, medical necessity, or benefit coverage.

(B) The department of banking, insurance, securities, and health care administration shall create a standardized form for the purpose of collecting the information described in subdivision (2)(A) of this subsection (a), and a health insurance company shall use the standardized form for reporting the required information as an addendum to its annual report. Where possible, the standardized form shall require that reported information be divided into categories determined by the department, including categories for coding errors, services not covered, and out-of-network providers.

(C)(i) The department of banking, insurance, securities, and health care administration shall post on its website the standardized forms completed by each health insurance company pursuant to subdivision (2)(B) of this subsection (a).

(ii) The department of Vermont health access shall post on the Vermont health benefit exchange an electronic link to the standardized forms posted by the department of banking, insurance, securities, and health care administration pursuant to subdivision (i) of this subdivision (2)(C).

(3) The statement of an alien insurer shall relate only to the insurer's transactions and affairs in the United States unless the commissioner requires otherwise.

(4) A foreign or alien company, upon withdrawing from the state of Vermont shall pay to the commissioner \$25.00 for the filing of its final financial statement.

Sec. 2. 8 V.S.A. § 4516 is amended to read:

§ 4516. ANNUAL REPORT TO COMMISSIONER

(a) Annually, on or before March 15, a hospital service corporation shall file with the commissioner of banking, insurance, securities, and health care administration a statement sworn to by the president and treasurer of the corporation showing its condition on December 31. The statement shall be in such form and contain such matters as the commissioner shall prescribe, including for hospital service corporations with a minimum of 200 Vermont

lives covered in the relevant reporting year or which offer a plan in the Vermont health benefit exchange pursuant to 33 V.S.A. § 1803:

(1) the total number of claims submitted to the hospital service corporation;

(2) the total number of denials of service by the hospital service corporation at the preauthorization level, including:

(A) the total number of denials of service at the preauthorization level appealed to the hospital service corporation at the first level grievance;

(B) the total number of denials of service at the preauthorization level overturned at the first level grievance;

(C) the total number of denials of service at the preauthorization level appealed to the hospital service corporation at any second level grievance;

(D) the total number of denials of service at the preauthorization level overturned at any second level grievance; and

(E) the total number of denials of service at the preauthorization level for which external review is sought and the number overturned by external review;

(3) the total number of service claims denied by the hospital service corporation, including:

(A) the total number of denied service claims appealed to the hospital service corporation at the first level grievance;

(B) the total number of denied service claims overturned at the first level grievance;

(C) the total number of denied service claims appealed to the hospital service corporation at any second level grievance;

(D) the total number of denied service claims overturned at any second level grievance; and

(E) the total number of denied service claims for which external review is sought and the number overturned by external review; and

(4) the total number of claims denied by a hospital service corporation for reasons not related to network issue, medical necessity, or benefit coverage.

(b)(1) The department of banking, insurance, securities, and health care administration shall create a standardized form for the purpose of collecting the information described in subsection (a) of this section, and a hospital

service corporation shall use the standardized form for reporting the required information as an addendum to its annual report. Where possible, the standardized form shall require that reported information be divided into categories determined by the department, including categories for coding errors, services not covered, and out-of-network providers.

(2)(A) The department of banking, insurance, securities, and health care administration shall post on its website the standardized forms completed by each hospital service corporation pursuant to subdivision (1) of this subsection (b).

(B) The department of Vermont health access shall post on the Vermont health benefit exchange an electronic link to the standardized forms posted by the department of banking, insurance, securities, and health care administration pursuant to subdivision (2)(A) of this subsection (b).

(c) To qualify for the tax exemption set forth in section 4518 of this title, the statement shall include a certification that the hospital service corporation operates on a nonprofit basis for the purpose of providing an adequate hospital service plan to individuals of the state, both groups and nongroups, without discrimination based on age, gender, geographic area, industry, and medical history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

Sec. 3. 8 V.S.A. § 4588 is amended to read:

§ 4588. ANNUAL REPORT TO COMMISSIONER

(a) Annually, on or before March 15, a medical service corporation shall file with the commissioner of banking, insurance, securities, and health care administration a statement sworn to by the president and treasurer of the corporation showing its condition on December 31, which shall be in such form and contain such matters as the commissioner shall prescribe, including for medical service corporations with a minimum of 200 Vermont lives covered in the relevant reporting year or which offer a plan in the Vermont health benefit exchange pursuant to 33 V.S.A. § 1803:

(1) the total number of claims submitted to the medical service corporation;

(2) the total number of denials of service by the medical service corporation at the preauthorization level, including:

(A) the total number of denials of service at the preauthorization level appealed to the medical service corporation at the first level grievance;

(B) the total number of denials of service at the preauthorization level overturned at the first level grievance;

(C) the total number of denials of service at the preauthorization level appealed to the medical service corporation at any second level grievance;

(D) the total number of denials of service at the preauthorization level overturned at any second level grievance; and

(E) the total number of denials of service at the preauthorization level for which external review is sought and the number overturned by external review;

(3) the total number of service claims denied by the medical service corporation, including:

(A) the total number of denied service claims appealed to the medical service corporation at the first level grievance;

(B) the total number of denied service claims overturned at the first level grievance;

(C) the total number of denied service claims appealed to the medical service corporation at any second level grievance;

(D) the total number of denied service claims overturned at any second level grievance; and

(E) the total number of denied service claims for which external review is sought and the number overturned by external review; and

(4) the total number of claims denied by a medical service corporation for reasons not related to network issue, medical necessity, or benefit coverage.

(b)(1) The department of banking, insurance, securities, and health care administration shall create a standardized form for the purpose of collecting the information described in subsection (a) of this section, and a medical service corporation shall use the standardized form for reporting the required information as an addendum to its annual report. Where possible, the standardized form shall require that reported information be divided into categories determined by the department, including categories for coding errors, services not covered, and out-of-network providers.

(2)(A) The department of banking, insurance, securities, and health care administration shall post on its website the standardized forms completed by each medical service corporation pursuant to subdivision (1) of this subsection (b).

(B) The department of Vermont health access shall post on the Vermont health benefit exchange an electronic link to the standardized forms

posted by the department of banking, insurance, securities, and health care administration pursuant to subdivision (2)(A) of this subsection (b).

(c) To qualify for the tax exemption set forth in section 4590 of this title, the statement shall include a certification that the medical service corporation operates on a nonprofit basis for the purpose of providing an adequate medical service plan to individuals of the state, both groups and nongroups, without discrimination based on age, gender, geographic area, industry, and medical history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

Sec. 4. 8 V.S.A. § 5106(a) is amended to read:

(a)(1) Every organization subject to this chapter, annually, within 120 days of the close of its fiscal year, shall file a report with the commissioner, said report verified by an appropriate official of the organization, showing its financial condition on the last day of the preceding fiscal year. The report shall be prepared in accordance with the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual for health maintenance organizations and shall be in such general form and context, as approved by, and shall contain any other information required by the National Association of Insurance Commissioners together with any useful or necessary modifications or adaptations thereof required, approved or accepted by the commissioner for the type of organization to be reported upon, and as supplemented by additional information required by the commissioner, including for organizations with a minimum of 200 Vermont lives covered in the relevant reporting year or which offer a plan in the Vermont health benefit exchange pursuant to 33 V.S.A. § 1803:

(A) the total number of claims submitted to the organization;

(B) the total number of denials of service by the organization at the preauthorization level, including:

(i) the total number of denials of service at the preauthorization level appealed to the organization at the first level grievance;

(ii) the total number of denials of service at the preauthorization level overturned at the first level grievance;

(iii) the total number of denials of service at the preauthorization level appealed to the organization at any second level grievance;

(iv) the total number of denials of service at the preauthorization level overturned at any second level grievance; and

(v) the total number of denials of service at the preauthorization level for which external review is sought and the number overturned by external review;

(C) the total number of service claims denied by the organization, including:

(i) the total number of denied service claims appealed to the organization at the first level grievance;

(ii) the total number of denied service claims overturned at the first level grievance;

(iii) the total number of denied service claims appealed to the organization at any second level grievance;

(iv) the total number of denied service claims overturned at any second level grievance; and

(v) the total number of denied service claims for which external review is sought and the number overturned by external review; and

(D) the total number of claims denied by an organization for reasons not related to network issue, medical necessity, or benefit coverage.

(2)(A) The department of banking, insurance, securities, and health care administration shall create a standardized form for the purpose of collecting the information described in subdivision (1) of this subsection (a), and an organization shall use the standardized form for reporting the required information as an addendum to its annual report. Where possible, the standardized form shall require that reported information be divided into categories determined by the department, including categories for coding errors, services not covered, and out-of-network providers.

(B)(i) The department of banking, insurance, securities, and health care administration shall post on its website the standardized forms completed by each organization pursuant to subdivision (2)(A) of this subsection (a).

(ii) The department of Vermont health access shall post on the Vermont health benefit exchange an electronic link to the standardized forms posted by the department of banking, insurance, securities, and health care administration pursuant to subdivision (2)(B)(i) of this subsection (a).

Sec. 5. EFFECTIVE DATE

This act shall take effect on July 1, 2012.