S.152

Introduced by Committee on Finance

Date: March 13, 2013

Subject: Health; health insurance; Green Mountain Care Board; rate review

Statement of purpose of bill as introduced: This bill proposes to provide the Green Mountain Care Board with the sole authority for approving, modifying, and denying health insurance rate requests for major medical insurance policies. It would also permit the Commissioner of Financial Regulation and the Green Mountain Care Board to modify the allocation of expenses for carrying out their regulatory and administrative duties and would require them to report annually on the actual allocation of expenses for the previous calendar year.

~~An act relating to the Green Mountain Care Board's rate review authority~~

An act relating to health care financing.

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

~~Sec. 1. 8 V.S.A. § 4062 is amended to read:~~

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy filed by an insurer offering health insurance as defined in subdivision ~~3301~~(a)(2) of this ~~title, a nonprofit hospital or medical service corporation, health maintenance~~

~~organization, or a managed care organization and not exempted by subdivision~~ 3368(a)(4) of this title shall be delivered or issued for delivery in this ~~state~~ State, nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until~~:~~

~~(A)~~ a copy of the form~~,~~ and of the rules for the classification of risks has been filed with the Department of Financial Regulation and a copy of the premium rates~~, and rules for the classification of risks pertaining thereto have~~ has been filed with the ~~commissioner of financial regulation~~ Green Mountain Care Board; and

~~(B) a decision by~~ the Green Mountain Care ~~board~~ Board has ~~been applied by the commissioner as provided in subdivision (2) of this subsection~~ issued a decision approving, modifying, or disapproving the proposed rate.

(2)(A) ~~Prior to approving a rate pursuant to this subsection, the commissioner shall seek approval for such rate from the Green Mountain Care board established in 18 V.S.A. chapter 220. The commissioner shall make a recommendation to the Green Mountain Care board about whether to approve, modify, or disapprove the rate within 30 days of receipt of a completed application from an insurer. In the event that the commissioner does not make a recommendation to the board within the 30-day period, the commissioner shall be deemed to have recommended approval of the rate, and the Green~~

~~Mountain Care board shall review the rate request pursuant to subdivision (B) of this subdivision (2).~~

~~(B)~~ The Green Mountain Care ~~board~~ Board shall review rate requests ~~forwarded by the commissioner pursuant to subdivision (A) of this subdivision (2)~~ and shall approve, modify, or disapprove a rate request within ~~30~~ 90 calendar days ~~of receipt of the commissioner's recommendation or, in the absence of a recommendation from the commissioner, the expiration of the 30-day period following the department's receipt of the completed application. In the event that the board does not approve or disapprove a rate within 30 days, the board shall be deemed to have approved the rate request~~ after receipt of an initial rate filing from an insurer. If an insurer fails to provide necessary materials or other information to the Board in a timely manner, the Board may extend its review for a reasonable additional period of time, not to exceed 30 calendar days.

~~(C) The commissioner shall apply the decision of the Green Mountain Care board as to rates referred to the board within five business days of the board's decision.~~

(B) Prior to the Board's decision on a rate request, the Department of Financial Regulation shall provide the Board with an analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves.

~~(3) The commissioner~~ Board ~~shall review policies and rates to determine~~ whether a ~~policy or~~ rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this ~~state~~ State. ~~The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer.~~ In making this determination, the Board shall consider the analysis and opinion provided by the Department of Financial Regulation pursuant to subdivision (2)(B) of this subsection.

(b) ~~The commissioner may, after a hearing of which at least 20 days' written notice has been given to the insurer using such form, premium rate, or rule, withdraw approval on any of the grounds stated in this section. For premium rates, such withdrawal may occur at any time after applying the decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C) of this section. Disapproval pursuant to this subsection shall be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.~~

~~(c) In conjunction with a rate filing required by subsection (a) of this~~ section, an insurer shall file a plain language summary of ~~any requested rate increase of five percent or greater. If, during the plan year, the insurer files for rate increases that are cumulatively five percent or greater, the insurer shall file a summary applicable to the cumulative rate increase~~ the proposed rate. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human Services (HHS) requires for rate increases over 10 percent, and any other information required by the ~~commissioner~~ Board. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and shall include notification of the public comment period established in subsection ~~(d)~~(c) of this section. In addition, the insurer shall post the summaries on its website.

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

(2)(A) Beginning no later than January 1, ~~2012~~ 2014, the ~~commissioner~~ Board shall post the rate filings pursuant to subsection (a) of this section and summaries pursuant to subsection ~~(c)~~(b) of this section on the ~~department's~~

~~Board's website within five calendar days of 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 ~~department~~ Board shall provide an electronic mechanism for the public to comment on ~~proposed rate increases over five percent~~ all rate filings. The ~~public shall have 21 days from the posting of the summaries and filings to provide~~ 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 ~~department~~ Board shall review and consider the public comments prior to ~~submitting the policy or rate for the Green Mountain Care board's approval pursuant to subsection (a) of this section. The department shall provide the Green Mountain Care board with the public comments for its consideration in approving any rates~~ issuing its decision.

(3) In addition to the public comment provisions set forth in this subsection, a consumer representative 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 the Board to provide to its~~ contracting actuary, if any.

~~(e)~~(d)(1) 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 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.

(e) Thirty calendar days after making the rate filing and analysis available to the public pursuant to subsection (d) of this section, the Board shall:

(1) conduct a public hearing, at which the Board shall:

(A) call as witnesses the Commissioner of Financial Regulation or designee and the Board's contracting actuary, if any, unless all parties agree to ~~waive such testimony; and~~

~~(B) provide an opportunity for testimony from the insurer; the Health~~ Care Ombudsman; the consumer representative, if such person is not employed by the Health Care Ombudsman; and members of the public;

(2) at a public hearing, announce the Board's decision of whether to approve, modify, or disapprove the proposed rate; and

(3) issue its decision in writing.

(f)(1) The insurer shall notify its policyholders of the Board's decision in a timely manner, as defined by the Board by rule.

(2) Rates shall take effect on the date specified in the insurer's rate filing.

(3) If the Board has not issued its decision by the effective date specified in the insurer's rate filing, the insurer shall notify its policyholders of its pending rate request and of the effective date proposed by the insurer in its rate filing.

(g) An insurer, the consumer representative, and any member of the public with party status, as defined by the Board by rule, may appeal a decision of the Board approving, modifying, or disapproving the insurer's proposed rate to the Vermont Supreme Court.

(h)~~(1) The following provisions of this~~ This section shall apply only to policies for major medical insurance coverage and shall not apply to policies ~~for specific disease, accident, injury, hospital indemnity, dental care, vision~~

~~care, disability income, long-term care, or other limited benefit coverage:~~; to Medicare supplemental insurance; or

~~(A) the requirement in subdivisions (a)(1) and (2) of this section for the Green Mountain Care board's approval on rate requests;~~

~~(B) the review standards in subdivision (a)(3) of this section as to whether a policy or rate is affordable, promotes quality care, and promotes access to health care; and~~

~~(C) subsections (c) and (d) of this section.~~

~~(2) The exemptions from the provisions described in subdivisions (1)(A) through (C) of this subsection shall also apply~~ to benefit plans that are paid directly to an individual insured or to his or her assigns and for which the amount of the benefit is not based on potential medical costs or actual costs incurred.

~~(3) Medicare supplemental insurance policies shall be exempt only from the requirement in subdivisions (a)(1) and (2) of this section for the Green Mountain Care board's approval on rate requests and shall be subject to the remaining provisions of this section.~~

(i) Notwithstanding the procedures and timelines set forth in subsections (a) through (e) of this section, the Board may establish, by rule, a streamlined rate review process for certain rate decisions, including proposed rates

~~affecting fewer than a minimum number of covered lives and proposed rates~~ for which a de minimis increase, as defined by the Board by rule, is sought.

Sec. 2. 8 V.S.A. § 4062a is amended to read:

§ 4062a. FILING FEES

Each filing of a policy, contract, or document form or premium rates or rules, submitted pursuant to section 4062 of this title, shall be accompanied by payment to the ~~commissioner~~ Commissioner or the Green Mountain Care Board, as appropriate, of a nonrefundable fee of ~~$50.00~~ $150.00.

Sec. 3. 8 V.S.A. § 4089b(d)(1)(A) is amended to read:

(d)(1)(A) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization provided that the managed care organization is in compliance with the rules adopted by the ~~commissioner~~ Commissioner that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. In reviewing rates and forms pursuant to section 4062 of this title, the ~~commissioner~~ Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, shall consider the ~~compliance of the policy with the provisions of this section.~~

~~Sec. 4. 8 V.S.A. § 4512(b) is amended to read:~~

(b) Subject to the approval of the ~~commissioner~~ Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, a hospital service corporation may establish, maintain, and operate a medical service plan as defined in section 4583 of this title. The ~~commissioner~~ Commissioner or the Board may refuse approval if the ~~commissioner~~ Commissioner or the Board finds that the rates submitted are excessive, inadequate, or unfairly discriminatory, fail to protect the hospital service corporation's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

Sec. 5. 8 V.S.A. § 4513(c) is amended to read:

(c) In connection with a rate decision, the ~~commissioner~~ Green Mountain Care Board may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as ~~he~~ the Board finds, on the basis of competent and substantial evidence, necessary to ~~insure~~ ensure that benefits and services are provided at minimum cost under efficient and economical management of the corporation. The commissioner

~~Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and 9376,~~ the Green Mountain Care Board, shall not set the rate of payment or reimbursement made by the corporation to any physician, hospital, or other health care provider.

Sec. 6. 8 V.S.A. § 4515a is amended to read:

§ 4515a. FORM AND RATE FILING; FILING FEES

Every contract or certificate form, or amendment thereof, including the rates charged therefor by the corporation shall be filed with the ~~commissioner~~ Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, for ~~his or her~~ the Commissioner's or the Board's approval prior to issuance or use. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. In addition, each such filing shall be accompanied by payment to the ~~commissioner~~ Commissioner or the Board, as appropriate, of a nonrefundable fee of ~~$50.00~~ $150.00 and the plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 7. 8 V.S.A. § 4584(c) is amended to read:

(c) In connection with a rate decision, the ~~commissioner~~ Green Mountain Care Board may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as ~~he or she~~ the Board finds, on the basis of competent and substantial evidence, necessary to ~~insure~~ ensure that benefits and services are provided at minimum

~~cost under efficient and economical management of the corporation. The commissioner~~ Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and 9376, the Green Mountain Care Board, shall not set the rate of payment or reimbursement made by the corporation to any physician, hospital, or other health care provider.

Sec. 8. 8 V.S.A. § 4587 is amended to read:

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation which has received a permit from the ~~commissioner of financial regulation~~ Commissioner of Financial Regulation under section 4584 of this title shall not thereafter issue a contract to a subscriber or charge a rate therefor which is different from copies of contracts and rates originally filed with such ~~commissioner~~ Commissioner and approved by him or her at the time of the issuance to such medical service corporation of its permit, until it has filed copies of such contracts which it proposes to issue and the rates it proposes to charge therefor and the same have been approved by ~~such commissioner~~ the Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. Each such filing of a contract or the rate therefor shall be accompanied by payment to the ~~commissioner~~ Commissioner or the Board, as appropriate, of a ~~nonrefundable fee of $50.00~~ $150.00. ~~A medical service corporation shall file~~

~~a plain language summary of rate increases pursuant to section 4062 of this title.~~

Sec. 9. 8 V.S.A. § 5104 is amended to read:

§ 5104. FILING AND APPROVAL OF RATES AND FORMS; SUPPLEMENTAL ORDERS

(a)(1) A health maintenance organization which has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections 4062 and 4062a of this title. This requirement shall include the filing of administrative retentions for any business in which the organization acts as a third party administrator or in any other administrative processing capacity. The ~~commissioner~~ Commissioner or the Green Mountain Care Board, as appropriate, may request and shall receive any information that the ~~commissioner~~ Commissioner or the Board deems necessary to evaluate the filing. In addition to any other information requested, the ~~commissioner~~ Commissioner or the Board shall require the filing of information on costs for providing services to the organization's Vermont members affected by the policy form or rate, including Vermont claims experience, and administrative and overhead costs allocated to the service of Vermont members. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. A health maintenance

~~organization shall file a summary of rate filings pursuant to section 4062 of~~ this title.

(2) The ~~commissioner~~ Commissioner or the Board shall refuse to approve~~, or to seek the Green Mountain Care board's approval of,~~ the form of evidence of coverage, filing, or rate if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of the ~~state~~ State or plan of operation, or if the rates are excessive, inadequate or unfairly discriminatory, fail to protect the organization's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. No evidence of coverage shall be offered to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

(b) In connection with a rate decision, the ~~commissioner~~ Board may also~~,~~ ~~with the prior approval of the Green Mountain Care board established in 18 V.S.A. chapter 220,~~ make reasonable supplemental orders and may attach reasonable conditions and limitations to such orders as the ~~commissioner~~ Board finds, on the basis of competent and substantial evidence, necessary to ~~insure~~ ensure that benefits and services are provided at reasonable cost under efficient and economical management of the organization. The ~~commissioner~~ Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and ~~9376, the Green Mountain Care Board,~~ shall not set the rate of payment or

~~reimbursement made by the organization to any physician, hospital, or health~~ care provider.

Sec. 10. 18 V.S.A. § 9375(b) is amended to read:

(b) The ~~board~~ Board shall have the following duties:

* * *

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 ~~within 30 days of receipt of a request for approval from the commissioner of financial regulation~~, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, protecting insurer solvency, and other issues at the discretion of the ~~board~~ Board;

* * *

Sec. 11. 18 V.S.A. § 9374(h) is amended to read:

(h)(1) ~~Expenses~~ Except as otherwise provided in subdivision (2) of this subsection, expenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by the ~~board~~ Board shall be borne as follows:

(A) 40 percent by the ~~state~~ State from state monies;

(B) 15 percent by the hospitals;

(C) 15 percent by nonprofit hospital and medical service corporations ~~licensed under 8 V.S.A. chapter 123 or 125~~;

~~(D) 15 percent by health insurance companies licensed under~~ 8 V.S.A. chapter 101; and

(E) 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.

~~(2) The Board may allocate expenses in a manner that deviates from the~~ allocation set forth in subdivision (1) of this subsection if, in the Board's discretion, the alternate allocation is in the best interests of the regulated entities and of the State.

(3) Expenses under subdivision (1) or, to the extent applicable, subdivision (2) of this subsection, shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or ~~stop loss, or excess loss insurance coverage~~.

(2) The Board may determine the scope of the incurred expenses to be allocated pursuant to the formula set forth in subdivision (1) of this subsection if, in the Board's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State.

(3) Expenses under subdivision (1) of this subsection shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

~~Sec. 12. 18 V.S.A. § 9375(d) is amended to read:~~

~~(d) Annually on or before January 15, the board~~ Board shall submit a report of its activities for the preceding ~~state fiscal~~ calendar year to the ~~house committee on health care and the senate committee on health and welfare~~ House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications, the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations, the process and outcome measures used in the evaluation, the actual allocation of expenses for the Board's administrative and regulatory activities pursuant to subsection 9374(h) of this title during the preceding calendar year, any recommendations for modifications to Vermont statutes, and any actual or anticipated impacts on the work of the ~~board~~ Board as a result of modifications to federal laws, regulations, or programs. The report shall identify how the work of the ~~board~~ Board comports with the ~~principles expressed in section 9371 of this title.~~

Sec. ~~13.~~*12.* 18 V.S.A. § 9415 is amended to read:

~~§ 9415. ALLOCATION OF EXPENSES~~

~~(a) Expenses~~ ~~Except as otherwise provided in subsection (b) of this section,~~ expenses incurred to obtain information and to analyze expenditures, review hospital budgets, and for any other related contracts authorized by the ~~commissioner~~ Commissioner shall be borne as follows:

(1) 40 percent by the ~~state~~ State from state monies~~,~~;

(2) 15 percent by the hospitals~~,~~;

(3) 15 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125~~,~~;

(4) 15 percent by health insurance companies licensed under 8 V.S.A. chapter 101~~,~~; and

(5) 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.

~~(b) The Commissioner may allocate expenses in a manner that deviates from the allocation set forth in subsection (a) of this section if, in the Commissioner's discretion, the alternate allocation is in the best interests of the regulated entities and of the State.~~

(c) Expenses under subsection (a) ~~or, to the extent applicable, subsection~~ (b) of this section, shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section include major medical, comprehensive medical, hospital or surgical coverage, ~~and any comprehensive health care services plan, but does shall not include~~

~~long-term care, limited benefits, disability, credit or stop loss,~~ or excess loss insurance coverage.

(d) Annually on or before January 15, the Commissioner shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance the actual allocation of expenses for the Department's administrative and regulatory activities pursuant to this section during the preceding calendar year.

(b) The Commissioner may determine the scope of the incurred expenses to be allocated pursuant to the formula set forth in subsection (a) of this section if, in the Commissioner's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State.

(c) Expenses under subsection (a) of this section shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section include major medical, comprehensive medical, hospital or surgical coverage, and any comprehensive health care services plan, but ~~does~~ shall not include long-term care, limited benefits, disability, credit or stop loss or excess loss insurance coverage.

Sec. 13. BILL-BACK REPORT

(a) Annually on or before September 15, the Green Mountain Care Board and the Department of Financial Regulation shall report to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the House and Senate Committees on Appropriations the total amount of all expenses eligible for allocation pursuant to 18 V.S.A. §§ 9374(h) and 9415 during the preceding state fiscal year and the total amount actually billed back to the regulated entities during the same period.

(b) The Board and the Department shall also present the information required by subsection (a) of this section to the Joint Fiscal Committee ~~annually at its September meeting.~~

~~Sec. 14. 18 V.S.A. § 9381 is amended to read:~~

§ 9381. APPEALS

(a)~~(1)~~ The Green Mountain Care ~~board~~ Board shall adopt procedures for administrative appeals of its actions, orders, or other determinations. Such procedures shall provide for the issuance of a final order and the creation of a record sufficient to serve as the basis for judicial review pursuant to subsection (b) of this section.

~~(2) Only decisions by the board shall be appealable under this subsection. Recommendations to the board by the commissioner of financial regulation pursuant to 8 V.S.A. § 4062(a) shall not be subject to appeal.~~

(b) Any person aggrieved by a final action, order, or other determination of the Green Mountain Care ~~board~~ Board may, upon exhaustion of all administrative appeals available pursuant to subsection (a) of this section, appeal to the ~~supreme court~~ Supreme Court pursuant to the Vermont Rules of Appellate Procedure.

(c) If an appeal or other petition for judicial review of a final order is not filed in connection with an order of the Green Mountain Care ~~board~~ Board pursuant to subsection (b) of this section, the ~~chair~~ Chair may file a certified copy of the final order with the clerk of a court of competent jurisdiction. The order so filed has the same effect as a judgment of the court and may be ~~recorded, enforced, or satisfied in the same manner as a judgment of the court.~~

~~(d) A decision of the Board approving, modifying, or disapproving a health~~ insurer's proposed rate pursuant to 8 V.S.A. § 4062 shall be considered a final action of the Board and may be appealed to the Supreme Court pursuant to subsection (b) of this section.

Sec. 15. 33 V.S.A. § 1811(j) is amended to read:

(j) The ~~commissioner~~ Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, shall disapprove any rates filed by any registered carrier, whether initial or revised, for insurance policies unless the anticipated medical loss ratios for the entire period for which rates are computed are at least 80 percent, as required by the ~~Patient Protection and~~ Affordable Care Act ~~(Public Law 111-148)~~.

Sec. 16. APPLICABILITY AND EFFECTIVE DATES

(a) Secs. 1–10, 14, and 15 (rate review) of this act shall take effect on January 1, 2014 and shall apply to all insurers filing rates and forms for major medical insurance plans on and after January 1, 2014, except that the Green Mountain Care Board and the Department of Financial Regulation may amend their rules and take such other actions before that date as are necessary to ensure that the revised rate review process will be operational on January 1, 2014.

(b) Secs. 11–13 (allocation of expenses) of this act shall take effect on ~~July 1, 2013.~~

Sec. 1. 21 V.S.A. § 2002 is amended to read:

§ 2002. DEFINITIONS

~~For the purposes of~~ As used in this chapter:

* * *

(5) "Uncovered employee" means:

(A) an employee of an employer who does not offer to pay any part of the cost of health care coverage for its employees;

(B) an employee who is not eligible for health care coverage offered by an employer to any other employees; or

(C) an employee who is offered and is eligible for coverage by the employer but elects not to accept the coverage and either:

(i) has no other health care coverage under either a private or public plan; or

(ii) has purchased health insurance coverage as an individual through the Vermont Health Benefit Exchange.

* * *

Sec. 2. 21 V.S.A. § 2003 is amended to read:

§ 2003. HEALTH CARE FUND CONTRIBUTION ASSESSMENT

* * *

(b) For any quarter in fiscal years 2007 and 2008, the amount of the ~~health care fund~~ Health Care Fund contribution shall be $ 91.25 for each full-time equivalent employee in excess of eight. For each fiscal year after fiscal year 2008, the number of excluded full-time equivalent employees shall be adjusted in accordance with subsection (a) of this section, and the amount of the ~~health care fund~~ Health Care Fund contribution shall be adjusted by a percentage equal to any percentage change in premiums for ~~Catamount Health for that fiscal year; provided, however, that to the extent that Catamount Health premiums decrease due to changes in benefit design or deductible amounts, the health care fund contribution shall not be decreased by the percentage change attributable to such benefit design or deductible changes~~ the second lowest cost silver-level plan in the Vermont Health Benefit Exchange.

* * *

(d) Revenues from the ~~health care fund~~ Health Care Fund contributions collected shall be deposited into the state ~~health care resources fund~~ Health Care Resources Fund established under 33 V.S.A. § 1901d.

Sec. 3. EFFECTIVE DATE

This act shall take effect on January 1, 2014.