

1 S.152

2 Introduced by Committee on Finance

3 Date: March 13, 2013

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

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

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

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

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

16 § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

17 (a)(1) No policy of health insurance or certificate under a policy filed by an  
18 insurer offering health insurance as defined in subdivision 3301(a)(2) of this  
19 title, a nonprofit hospital or medical service corporation, health maintenance  
20 organization, or a managed care organization and not exempted by subdivision

1 3368(a)(4) of this title shall be delivered or issued for delivery in this state  
2 State, nor shall any endorsement, rider, or application which becomes a part of  
3 any such policy be used, until:

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

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

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

1           ~~(B)~~ The Green Mountain Care board Board shall review rate requests  
2           ~~forwarded by the commissioner pursuant to subdivision (A) of this subdivision~~  
3           ~~(2)~~ and shall approve, modify, or disapprove a rate request within ~~30~~ 90  
4           calendar days of receipt of the commissioner's recommendation or, in the  
5           ~~absence of a recommendation from the commissioner, the expiration of the~~  
6           ~~30 day period following the department's receipt of the completed application.~~  
7           ~~In the event that the board does not approve or disapprove a rate within 30~~  
8           ~~days, the board shall be deemed to have approved the rate request~~ after receipt  
9           of an initial rate filing from an insurer. If an insurer fails to provide necessary  
10           materials or other information to the Board in a timely manner, the Board may  
11           extend its review for a reasonable additional period of time, not to exceed 30  
12           calendar days.

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

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

19           (3) The ~~commissioner~~ Board shall review ~~policies and rates to determine~~  
20           whether a ~~policy or~~ rate is affordable, promotes quality care, promotes access  
21           to health care, protects insurer solvency, and is not unjust, unfair, inequitable,

1 misleading, or contrary to the laws of this state State. ~~The commissioner shall~~  
2 ~~notify in writing the insurer which has filed any such form, premium rate, or~~  
3 ~~rule if it contains any provision which does not meet the standards expressed in~~  
4 ~~this section. In such notice, the commissioner shall state that a hearing will be~~  
5 ~~granted within 20 days upon written request of the insurer. In making this~~  
6 ~~determination, the Board shall consider the analysis and opinion provided by~~  
7 ~~the Department of Financial Regulation pursuant to subdivision (2)(B) of this~~  
8 ~~subsection.~~

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

18 (e) In conjunction with a rate filing required by subsection (a) of this  
19 section, an insurer shall file a plain language summary of ~~any requested rate~~  
20 ~~increase of five percent or greater. If, during the plan year, the insurer files for~~  
21 ~~rate increases that are cumulatively five percent or greater, the insurer shall file~~

1 a summary applicable to the cumulative rate increase the proposed rate. All  
2 summaries shall include a brief justification of any rate increase requested, the  
3 information that the Secretary of the U.S. Department of Health and Human  
4 Services (HHS) requires for rate increases over 10 percent, and any other  
5 information required by the ~~commissioner~~ Board. The plain language  
6 summary shall be in the format required by the Secretary of HHS pursuant to  
7 the Patient Protection and Affordable Care Act of 2010, Public Law 111-148,  
8 as amended by the Health Care and Education Reconciliation Act of 2010,  
9 Public Law 111-152, and shall include notification of the public comment  
10 period established in subsection ~~(d)~~(c) of this section. In addition, the insurer  
11 shall post the summaries on its website.

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

15 (2)(A) Beginning no later than January 1, ~~2012~~ 2014, the ~~commissioner~~  
16 Board shall post the rate filings pursuant to subsection (a) of this section and  
17 summaries pursuant to subsection ~~(e)~~(b) of this section on the ~~department's~~  
18 Board's website within five calendar days of filing. The Board shall also  
19 establish a mechanism by which members of the public may request to be  
20 notified automatically each time a proposed rate is filed with the Board.

1           (B) The ~~department~~ Board shall provide an electronic mechanism for  
2           the public to comment on ~~proposed rate increases over five percent~~ all rate  
3           filings. The ~~public shall have 21 days from the posting of the summaries and~~  
4           ~~filings to provide~~ Board shall accept public comment on each rate filing from  
5           the date on which the Board posts the rate filing on its website pursuant to  
6           subdivision (A) of this subdivision (2) until 15 calendar days after the Board  
7           posts on its website the analyses and opinions of the Department of Financial  
8           Regulation and of the Board's consulting actuary, if any, as required by  
9           subsection (d) of this section. The ~~department~~ Board shall review and consider  
10          the public comments prior to ~~submitting the policy or rate for the Green~~  
11          ~~Mountain Care board's approval pursuant to subsection (a) of this section~~. The  
12          ~~department shall provide the Green Mountain Care board with the public~~  
13          ~~comments for its consideration in approving any rates~~ issuing its decision.

14          (3) In addition to the public comment provisions set forth in this  
15          subsection, a consumer representative acting on behalf of health insurance  
16          consumers in this State may, within 30 calendar days after the Board receives  
17          an insurer's rate request pursuant to this section, submit to the Board, in  
18          writing, suggested questions regarding the filing for the Board to provide to its  
19          contracting actuary, if any.

20          ~~(e)(d)(1)~~ No later than 60 calendar days after receiving an insurer's rate  
21          request pursuant to this section, the Green Mountain Care Board shall make

1 available to the public the insurer's rate filing, the Department's analysis and  
2 opinion of the effect of the proposed rate on the insurer's solvency, and the  
3 analysis and opinion of the rate filing by the Board's contracting actuary, if  
4 any.

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

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

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

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

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

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

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

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

3           (3) issue its decision in writing.

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

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

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

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

16           ~~(h)(1) The following provisions of this~~ This section shall apply only to  
17 policies for major medical insurance coverage and shall not apply to policies  
18 for specific disease, accident, injury, hospital indemnity, dental care, vision  
19 care, disability income, long-term care, or other limited benefit coverage; to  
20 Medicare supplemental insurance; or

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

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

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

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

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

16           (i) Notwithstanding the procedures and timelines set forth in subsections  
17 (a) through (e) of this section, the Board may establish, by rule, a streamlined  
18 rate review process for certain rate decisions, including proposed rates  
19 affecting fewer than a minimum number of covered lives and proposed rates  
20 for which a de minimis increase, as defined by the Board by rule, is sought.

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

2 § 4062a. FILING FEES

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

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

8 (d)(1)(A) A health insurance plan that does not otherwise provide for  
9 management of care under the plan, or that does not provide for the same  
10 degree of management of care for all health conditions, may provide coverage  
11 for treatment of mental health conditions through a managed care organization  
12 provided that the managed care organization is in compliance with the rules  
13 adopted by the ~~commissioner~~ Commissioner that assure that the system for  
14 delivery of treatment for mental health conditions does not diminish or negate  
15 the purpose of this section. In reviewing rates and forms pursuant to section  
16 4062 of this title, the ~~commissioner~~ Commissioner or the Green Mountain Care  
17 Board established in 18 V.S.A. chapter 220, as appropriate, shall consider the  
18 compliance of the policy with the provisions of this section.

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

20 (b) Subject to the approval of the ~~commissioner~~ Commissioner or the  
21 Green Mountain Care Board established in 18 V.S.A. chapter 220, as

1 appropriate, a hospital service corporation may establish, maintain, and operate  
2 a medical service plan as defined in section 4583 of this title. The  
3 ~~commissioner~~ Commissioner or the Board may refuse approval if the  
4 ~~commissioner~~ Commissioner or the Board finds that the rates submitted are  
5 excessive, inadequate, or unfairly discriminatory, fail to protect the hospital  
6 service corporation's solvency, or fail to meet the standards of affordability,  
7 promotion of quality care, and promotion of access pursuant to section 4062 of  
8 this title. The contracts of a hospital service corporation which operates a  
9 medical service plan under this subsection shall be governed by chapter 125 of  
10 this title to the extent that they provide for medical service benefits, and by this  
11 chapter to the extent that the contracts provide for hospital service benefits.

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

13 (c) In connection with a rate decision, the ~~commissioner~~ Green Mountain  
14 Care Board may also make reasonable supplemental orders to the corporation  
15 and may attach reasonable conditions and limitations to such orders as ~~he~~ the  
16 Board finds, on the basis of competent and substantial evidence, necessary to  
17 ~~insure~~ ensure that benefits and services are provided at minimum cost under  
18 efficient and economical management of the corporation. The ~~commissioner~~  
19 Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and  
20 9376, the Green Mountain Care Board, shall not set the rate of payment or

1 reimbursement made by the corporation to any physician, hospital, or other  
2 health care provider.

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

4 § 4515a. FORM AND RATE FILING; FILING FEES

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

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

15 (c) In connection with a rate decision, the ~~commissioner~~ Green Mountain  
16 Care Board may also make reasonable supplemental orders to the corporation  
17 and may attach reasonable conditions and limitations to such orders as ~~he or~~  
18 ~~she~~ the Board finds, on the basis of competent and substantial evidence,  
19 necessary to ~~insure~~ ensure that benefits and services are provided at minimum  
20 cost under efficient and economical management of the corporation. The  
21 ~~commissioner~~ Commissioner and, except as otherwise provided by 18 V.S.A.

1 §§ 9375 and 9376, the Green Mountain Care Board, shall not set the rate of  
2 payment or reimbursement made by the corporation to any physician, hospital,  
3 or other health care provider.

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

5 § 4587. FILING AND APPROVAL OF CONTRACTS

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

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

2 § 5104. FILING AND APPROVAL OF RATES AND FORMS;

3 SUPPLEMENTAL ORDERS

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

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

11           (b) In connection with a rate decision, the ~~commissioner~~ Board may also,  
12 ~~with the prior approval of the Green Mountain Care board established in 18~~  
13 ~~V.S.A. chapter 220,~~ make reasonable supplemental orders and may attach  
14 reasonable conditions and limitations to such orders as the ~~commissioner~~  
15 Board finds, on the basis of competent and substantial evidence, necessary to  
16 ~~insure~~ ensure that benefits and services are provided at reasonable cost under  
17 efficient and economical management of the organization. The ~~commissioner~~  
18 Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and  
19 9376, the Green Mountain Care Board, shall not set the rate of payment or  
20 reimbursement made by the organization to any physician, hospital, or health  
21 care provider.

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

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

3 \* \* \*

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

10 \* \* \*

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

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

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

17 (B) 15 percent by the hospitals;

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

20 (D) 15 percent by health insurance companies licensed under  
21 8 V.S.A. chapter 101; and

1 (E) 15 percent by health maintenance organizations licensed under  
2 8 V.S.A. chapter 139.

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

7 (3) Expenses under subdivision (1) or, to the extent applicable,  
8 subdivision (2) of this subsection, shall be billed to persons licensed under  
9 Title 8 based on premiums paid for health care coverage, which for the  
10 purposes of this section shall include major medical, comprehensive medical,  
11 hospital or surgical coverage, and comprehensive health care services plans,  
12 but shall not include long-term care or limited benefits, disability, credit or  
13 ~~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.~~

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

15 (d) Annually on or before January 15, the ~~board~~ Board shall submit a report  
16 ~~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

1 hospital budgets, and for any other related contracts authorized by the  
2 ~~commissioner~~ Commissioner shall be borne as follows:

3 (1) 40 percent by the ~~state~~ State from state monies;

4 (2) 15 percent by the hospitals;

5 (3) 15 percent by nonprofit hospital and medical service corporations  
6 licensed under 8 V.S.A. chapter 123 or 125;

7 (4) 15 percent by health insurance companies licensed under 8 V.S.A.  
8 chapter 101; and

9 (5) 15 percent by health maintenance organizations licensed under  
10 8 V.S.A. chapter 139.

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

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

1 ~~(d) Annually on or before January 15, the Commissioner shall report to the~~  
2 ~~House Committee on Health Care and the Senate Committees on Health and~~  
3 ~~Welfare and on Finance the actual allocation of expenses for the Department's~~  
4 ~~administrative and regulatory activities pursuant to this section during the~~  
5 ~~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.*

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

7 § 9381. APPEALS

8 (a)(1) The Green Mountain Care ~~board~~ Board shall adopt procedures for  
9 administrative appeals of its actions, orders, or other determinations. Such  
10 procedures shall provide for the issuance of a final order and the creation of a

1 record sufficient to serve as the basis for judicial review pursuant to subsection  
2 (b) of this section.

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

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

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

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

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

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

8 Sec. 16. APPLICABILITY AND EFFECTIVE DATES

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

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