H.107

Senator Lyons moves that the Senate Proposal of Amendment be further amended as follows:

First: In Sec. 3, 8 V.S.A. § 4089i, in subdivisions (e)(1) and (f)(1), preceding "pharmacy benefit manager" in both places it appears, by inserting the words by a and following "pharmacy benefit manager" in both places it appears, by inserting the words on behalf of a health insurer

Second: By striking out Sec. 5a in its entirety and inserting in lieu thereof a new Sec. 5a to read as follows:

Sec. 5a. 18 V.S.A. § 9418b(g)(4) is amended to read:

(4) A health plan shall respond to a completed prior authorization request from a prescribing health care provider within 48 hours for urgent requests and within ~~120 hours~~ two business days of receipt for non-urgent requests. The health plan shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours of receipt. If a health plan does not, within the time limits set forth in this section, respond to a completed prior authorization request, acknowledge receipt of the request for prior authorization, or request missing information, the prior authorization request shall be deemed to have been granted.

Third: In Sec. 5b, standardized health insurance claims and edits, in subdivision (a)(1), following "January 1, 2015" by inserting before the period and that Medicaid shall use beginning on January 1, 2017

Fourth: In Sec. 5b, standardized health insurance claims and edits, in subdivision (c)(1), following "January 1,", by striking out "2015" and inserting in lieu thereof 2017

Fifth: In Sec. 5b, standardized health insurance claims and edits, in subsection (d), by striking out subdivision (2) in its entirety and inserting in lieu thereof a new subdivision (2) to read as follows:

(2) "Health insurer" means a health insurance company, a nonprofit hospital or medical service corporation, a managed care organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by a public or private entity.

Sixth: In Sec. 5c, 8 V.S.A. § 4062, in subdivision (c)(3), by designating the existing subdivision to be subdivision (3)(A), by striking out "Health Care Ombudsman" and inserting in lieu thereof Office of the Health Care Advocate established in 18 V.S.A. chapter 229, and by adding a subdivision (3)(B) to read as follows:

(B) The Office of the Health Care Advocate may also submit to the Board written comments on an insurer's rate request. The Board shall post the

comments on its website and shall consider the comments prior to issuing its decision.

Seventh: In Sec. 5c, 8 V.S.A. § 4062, in subdivision (e)(1)(B), by striking out "Health Care Ombudsman" and inserting in lieu thereof Office of the Health Care Advocate

Eighth: In Sec. 5c, 8 V.S.A. § 4062, in subsection (g), by striking out "Health Care Ombudsman" and inserting in lieu thereof Office of the Health Care Advocate

Ninth: By adding Secs. 35a–35h to read as follows:

* * * Office of the Health Care Advocate * * *

Sec. 35a. 18 V.S.A. chapter 229 is added to read:

CHAPTER 229. OFFICE OF THE HEALTH CARE ADVOCATE

§ 9601. DEFINITIONS

As used in this chapter:

(1) "Green Mountain Care Board" or "Board" means the Board established in chapter 220 of this title.

(2) "Health insurance plan" means a policy, service contract, or other health benefit plan offered or issued by a health insurer and includes beneficiaries covered by the Medicaid program unless they are otherwise provided with similar services.

(3) "Health insurer" shall have the same meaning as in section 9402 of this title.

§ 9602. OFFICE OF THE HEALTH CARE ADVOCATE; COMPOSITION

(a) The Agency of Administration shall establish the Office of the Health Care Advocate by contract with any nonprofit organization.

(b) The Office shall be administered by the Chief Health Care Advocate, who shall be an individual with expertise and experience in the fields of health care and advocacy. The Advocate may employ legal counsel, administrative staff, and other employees and contractors as needed to carry out the duties of the Office.

§ 9603. DUTIES AND AUTHORITY

(a) The Office of the Health Care Advocate shall:

(1) Assist health insurance consumers with health insurance plan selection by providing information, referrals, and assistance to individuals about means of obtaining health insurance coverage and services. The Office shall accept referrals from the Vermont Health Benefit Exchange and Exchange navigators created pursuant to 33 V.S.A. chapter 18, subchapter 1, to assist consumers experiencing problems related to the Exchange.

(2) Assist health insurance consumers to understand their rights and responsibilities under health insurance plans.

(3) Provide information to the public, agencies, members of the General Assembly, and others regarding problems and concerns of health insurance consumers as well as recommendations for resolving those problems and concerns.

(4) Identify, investigate, and resolve complaints on behalf of individual health insurance consumers, and assist those consumers with filing and pursuit of complaints and appeals.

(5) Provide information to individuals regarding their obligations and responsibilities under the Patient Protection and Affordable Care Act (Public Law 111-148).

(6) Analyze and monitor the development and implementation of federal, state, and local laws, rules, and policies relating to patients and health insurance consumers.

(7) Facilitate public comment on laws, rules, and policies, including policies and actions of health insurers.

(8) Suggest policies, procedures, or rules to the Green Mountain Care Board in order to protect patients' and consumers' interests.

(9) Promote the development of citizen and consumer organizations.

(10) Ensure that patients and health insurance consumers have timely access to the services provided by the Office.

(11) Submit to the General Assembly and the Governor on or before January 1 of each year a report on the activities, performance, and fiscal accounts of the Office during the preceding calendar year.

(b) The Office of the Health Care Advocate may:

(1) Review the health insurance records of a consumer who has provided written consent. Based on the written consent of the consumer or his or her guardian or legal representative, a health insurer shall provide the Office with access to records relating to that consumer.

(2) Pursue administrative, judicial, and other remedies on behalf of any individual health insurance consumer or group of consumers.

(3) Represent the interests of the people of the State in cases requiring a hearing before the Green Mountain Care Board established in chapter 220 of this title.

(4) Adopt policies and procedures necessary to carry out the provisions of this chapter.

(5) Take any other action necessary to fulfill the purposes of this chapter.

(c) The Office of the Health Care Advocate shall be able to speak on behalf of the interests of health care and health insurance consumers and to carry out all duties prescribed in this chapter without being subject to any retaliatory

action; provided, however, that nothing in this subsection shall limit the authority of the Agency of Administration to enforce the terms of the contract.

§ 9604. DUTIES OF STATE AGENCIES

All state agencies shall comply with reasonable requests from the Office of the Health Care Advocate for information and assistance. The Agency of Administration may adopt rules necessary to ensure the cooperation of state agencies under this section.

§ 9605. CONFIDENTIALITY

In the absence of written consent by a complainant or an individual using the services of the Office or by his or her guardian or legal representative or the absence of a court order, the Office of the Health Care Advocate, its employees, and its contractors shall not disclose the identity of the complainant or individual.

§ 9606. CONFLICTS OF INTEREST

The Office of the Health Care Advocate, its employees, and its contractors shall not have any conflict of interest relating to the performance of their responsibilities under this chapter. For the purposes of this chapter, a conflict of interest exists whenever the Office of the Health Care Advocate, its employees, or its contractors or a person affiliated with the Office, its employees, or its contractors:

(1) have a direct involvement in the licensing, certification, or accreditation of a health care facility, health insurer, or health care provider;

(2) have a direct ownership interest or investment interest in a health care facility, health insurer, or health care provider;

(3) are employed by or participating in the management of a health care facility, health insurer, or health care provider; or

(4) receive or have the right to receive, directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer, or health care provider.

§ 9607. FUNDING; INTENT

(a) The Office of the Health Care Advocate shall specify in its annual report filed pursuant to this chapter the sums expended by the Office in carrying out its duties, including identifying the specific amount expended for actuarial services.

(b) It is the intent of the General Assembly that the Office of the Health Care Advocate shall maximize the amount of federal and grant funds available to support the activities of the Office.

Sec. 35b. 18 V.S.A. § 9374(f) is amended to read:

(f) In carrying out its duties pursuant to this chapter, the ~~board~~ Board shall seek ~~the~~ advice ~~of the state health care ombudsman established in 8 V.S.A. § 4089w~~ from the Office of the Health Care Advocate. The ~~state health care~~

~~ombudsman~~ Office shall advise the ~~board~~ Board regarding the policies, procedures, and rules established pursuant to this chapter. The ~~ombudsman~~ Office shall represent the interests of Vermont patients and Vermont consumers of health insurance and may suggest policies, procedures, or rules to the ~~board~~ Board in order to protect patients' and consumers' interests.

Sec. 35c. 18 V.S.A. § 9377(e) is amended to read:

(e) The ~~board~~ Board or designee shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the ~~state health care ombudsman~~ Office of the Health Care Advocate, and state and local governments, to advise the ~~board~~ Board in developing and implementing the pilot projects and to advise the Green Mountain Care ~~board~~ Board in setting overall policy goals.

Sec. 35d. 18 V.S.A. § 9410(a)(2) is amended to read:

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the ~~commissioner~~ Commissioner determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(B) The ~~commissioner~~ Commissioner shall convene a working group composed of the ~~commissioner of mental health, the commissioner of Vermont health access~~ Commissioner of Mental Health, the Commissioner of Vermont Health Access, health care consumers, the ~~office of the health care ombudsman~~ Office of the Health Care Advocate, employers and other payers, health care providers and facilities, the Vermont ~~program for quality in health care~~ Program for Quality in Health Care, health insurers, and any other individual or group appointed by the ~~commissioner~~ Commissioner to advise the ~~commissioner~~ Commissioner on the development and implementation of the consumer health care price and quality information system.

* * *

Sec. 35e. 18 V.S.A. § 9440(c) is amended to read:

(c) The application process shall be as follows:

* * *

(9) The ~~health care ombudsman's office~~ Office of the Health Care Advocate established under ~~8 V.S.A. chapter 107, subchapter 1A~~ chapter 229 of this title or, in the case of nursing homes, the ~~long-term care ombudsman's office~~ Long-Term Care Ombudsman's Office established under 33 V.S.A. § 7502~~,~~ is authorized but not required to participate in any administrative or judicial review of an application under this subchapter and shall be considered

an interested party in such proceedings upon filing a notice of intervention with the ~~board~~ Board.

Sec. 35f. 18 V.S.A. § 9445(b) is amended to read:

(b) In addition to all other sanctions, if any person offers or develops any new health care project without first having been issued a certificate of need or certificate of exemption ~~therefore~~ for the project, or violates any other provision of this subchapter or any lawful rule ~~or regulation promulgated thereunder~~ adopted pursuant to this subchapter, the ~~board~~ Board, the ~~commissioner~~ Commissioner, the ~~state health care ombudsman~~ Office of the Health Care Advocate, the ~~state long-term care ombudsman~~ State Long-Term Care Ombudsman, and health care providers and consumers located in the ~~state~~ State shall have standing to maintain a civil action in the ~~superior court~~ Superior Court of the county ~~wherein~~ in which such alleged violation has occurred, or ~~wherein~~ in which such person may be found, to enjoin, restrain, or prevent such violation. Upon written request by the ~~board~~ Board, it shall be the duty of the ~~attorney general of the state~~ Vermont Attorney General to furnish appropriate legal services and to prosecute an action for injunctive relief to an appropriate conclusion, which shall not be reimbursed under subdivision (a)(2) of this ~~subsection~~ section.

Sec. 35g. 33 V.S.A. § 1805 is amended to read:

§ 1805. DUTIES AND RESPONSIBILITIES

The Vermont ~~health benefit exchange~~ Health Benefit Exchange shall have the following duties and responsibilities consistent with the Affordable Care Act:

* * *

(16) Referring consumers to the ~~office of health care ombudsman~~ Office of the Health Care Advocate for assistance with grievances, appeals, and other issues involving the Vermont ~~health benefit exchange~~ Health Benefit Exchange.

* * *

Sec. 35h. 33 V.S.A. § 1807(b) is amended to read:

(b) Navigators shall have the following duties:

* * *

(4) Provide referrals to the ~~office of health care ombudsman~~ Office of the Health Care Advocate and any other appropriate agency for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage;

* * *

Tenth: By adding a Sec. 37d to read as follows:

Sec. 37d. HEALTH CARE ADVOCATE; BILL BACK

(a) Through June 30, 2016, financial support for the Office of the Health Care Advocate established pursuant to 18 V.S.A. chapter 229 for services related to the Green Mountain Care Board's and Department of Financial Regulation's regulatory and supervisory duties shall be considered expenses incurred by the Board or the Department under 18 V.S.A. §§ 9374(h) and 9415 and shall be an acceptable use of the funds realized pursuant to those sections.

(b) For fiscal year 2014, the Green Mountain Care Board and the Department of Financial Regulation may allocate up to $300,000.00 of expenses pursuant to the authority granted by subsection (a) of this section.

(c) On or before February 1, 2014, the Director of Health Care Reform in the Agency of Administration shall present to the House Committees on Health Care, on Ways and Means, and on Appropriations and the Senate Committees on Health and Welfare, on Finance, and on Appropriations sustainable funding options for the Office of the Health Care Advocate, including sustainable options based on sources other than the allocation of expenses described in subsection (a) of this section.

Eleventh: By adding Secs. 40a–40c to read as follows:

* * * Prior Authorizations * * *

Sec. 40a. 18 V.S.A. § 9377a is added to read:

§ 9377a. PRIOR AUTHORIZATION PILOT PROGRAM

(a) The Green Mountain Care Board shall develop and implement a pilot program or programs for the purpose of measuring the change in system costs within primary care associated with eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care. The program shall be designed to measure the effects of eliminating prior authorizations on provider satisfaction and on the number of requests for and expenditures on imaging, medical procedures, prescription drugs, and home care. In developing the pilot program proposal, the Board shall collaborate with health care professionals and health insurers throughout the State or regionally.

(b) The Board shall submit an update regarding implementation of prior authorization pilot programs as part of its annual report under subsection 9375(d) of this title.

Sec. 40b. 18 V.S.A. § 9414a(a)(5) is amended to read:

(5) data regarding the number of denials of service by the health insurer at the preauthorization level, including:

(A) the total number of denials of service by the health insurer at the preauthorization level~~, including:~~;

~~(A)~~(B) the total number of denials of service at the preauthorization level appealed to the health insurer at the first-level grievance and, of those, the total number overturned; and

~~(B)~~(C) the total number of denials of service at the preauthorization level appealed to the health insurer at any second-level grievance and, of those, the total number overturned;

~~(C)~~(D) the total number of denials of service at the preauthorization level for which external review was sought and, of those, the total number overturned;

Sec. 40c. DENIED CLAIMS; DEPARTMENT OF VERMONT HEALTH ACCESS

On or before February 1, 2014, the Department of Vermont Health Access shall present data to the House Committee on Health Care and the Senate Committee on Health and Welfare on claims denied by the Department. To the extent practicable, the Department shall base its presentation on the data required by the standardized form created by the Department of Financial Regulation for use by health insurers under 18 V.S.A. § 9414a(c).

Twelfth: In Sec. 52, repeals, by adding a subsection (f) to read as follows:

(f) 8 V.S.A. § 4089w (Health Care Ombudsman) is repealed on January 1, 2014.

Thirteenth: By striking out Sec. 53, effective dates, in its entirety and inserting in lieu thereof a new Sec. 53 to read as follows:

* * * Effective Dates * * *

Sec. 53. EFFECTIVE DATES

(a) Secs. 2 (mental health care services review), 3(d) (8 V.S.A. § 4089i(d)(prescription drug deductibles), 5a (prior authorization), 5b (standardized claims and edits), 33–34a (health information exchange), 35 (hospital energy efficiency), 39 (publication extension for 2013 hospital reports), 40 (VHCURES), 43 and 44 (workforce planning), 46 (DVHA antitrust provision), 48 (Exchange options), 49 (correction to payment reform pilot repeal), 50 (transfer of positions), 51 (emergency rules), and 52 (repeals) of this act and this section shall take effect on passage.

(b) Sec. 1 (interstate employers) and Secs. 28–30 (employer definitions) shall take effect on October 1, 2013 for the purchase of insurance plans effective for coverage beginning January 1, 2014.

(c) Secs. 4 (newborn coverage), 5 (grace period for premium payment), 6–27 (Catamount and VHAP), 35a–35h (Office of the Health Care Advocate), and 47 (pharmacy program enrollment) shall take effect on January 1, 2014.

(d) Secs. 31 (Healthy Vermonters) and 32 (VPharm) shall take effect on January 1, 2014, except that the Department of Vermont Health Access may continue to calculate household income under the rules of the Vermont Health Access Plan after that date if the system for calculating modified adjusted gross income for the Healthy Vermonters and VPharm programs is not operational by that date, but no later than December 31, 2014.

(e) Secs. 5c–5n (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.

(f) Sec. 42a (Exchange impact report) shall take effect on July 1, 2014.

(g) Sec. 3(e)–(g) (8 V.S.A. § 4089i(e)–(g); step therapy) shall take effect on September 1, 2013 and shall apply to all health insurers on and after September 1, 2013 on such date as a health insurer offers, issues, or renews a health insurance policy, but in no event later than September 1, 2014.

(h) All remaining sections of this act shall take effect on July 1, 2013.