TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred Senate Bill No. 152 entitled "An act relating to the Green Mountain Care Board's rate review authority" respectfully reports that it has considered the same and recommends that the House propose to the Senate that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Health Insurance Rate Review * * *

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)(A) In addition to the public comment provisions set forth in this subsection, the Office of the Health Care Advocate established in 18 V.S.A. chapter 229 may, within 30 calendar days after the Board receives an insurer's rate request pursuant to this section, submit questions regarding the filing to the insurer and to the Board's contracting actuary, if any.

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

~~(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;

(B) all questions the Office of the Health Care Advocate poses to the Board's contracting actuary, if any, and the actuary's responses to the Office's questions; and

(C) all questions the Board, the Board's contracting actuary, if any, the Department, or the Office of the Health Care Advocate poses to the insurer and the insurer's responses to those questions.

(e) Within 30 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 Office of the Health Care Advocate, 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 Office of the Health Care Advocate, 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. § 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. 12. 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)~~.

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

Sec. 13. 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 and employers with not more than 10 full-time equivalent employees 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 employers with not more than 10 full-time equivalent employees who purchase insurance for their employees, and assist those consumers with filing and pursuit of complaints and appeals.

(5) Provide information to individuals and employers 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 disciplinary or retaliatory action; provided, however, that nothing in this subsection shall limit the authority of the Director of Health Care Reform 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. CONSUMER ASSISTANCE ASSESSMENT

(a) The premium for each health insurance policy issued in this state shall include a monthly consumer assistance assessment of $0.22 per covered life to fund the activities of the Office of the Health Care Advocate. Each health insurer shall remit the assessments collected during the preceding calendar quarter to the Commissioner of Financial Regulation by January 15, April 15, July 15, and October 15 of each year.

(b) There is established pursuant to 32 V.S.A. chapter 7, subchapter 5 a special fund called the "Consumer Assistance Assessment Fund" into which shall be deposited the funds collected under this section. The fund shall be administered by the Secretary of Administration and disbursements are authorized to fund the activities of the Office of the Health Care Advocate as appropriated by the General Assembly.

(c) As used in this section:

(1) "Health insurance" means any group or individual health care benefit policy, contract, or other health benefit plan offered, issued, renewed, or administered by any health insurer, including any health care benefit plan offered, issued, renewed, or administered by any health insurance company,

any nonprofit hospital and medical service corporation, or any managed care organization as defined in section 9402 of this title. The term includes comprehensive major medical policies, contracts, or plans but does not include Medicaid or any other state health care assistance program financed in whole or in part through a federal program. The term does not include policies issued for specified disease, accident, injury, hospital indemnity, dental care, long-term care, disability income, or other limited benefit health insurance policies.

(2) "Health insurer" means any person who offers, issues, renews, or administers a health insurance policy, contract, or other health benefit plan in this State and includes third-party administrators or pharmacy benefit managers who provide administrative services only for a health benefit plan offering coverage in this State. The term does not include a third-party administrator or pharmacy benefit manager to the extent that a health insurer has collected and remitted the surcharges which would otherwise be imposed on the covered lives attributed to the third-party administrator or pharmacy benefit manager. The term also does not include a health insurer with a monthly average of fewer than 200 Vermont insured lives.

Sec. 14. 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. 15. 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. 16. 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. 17. 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. 18. 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. 19. 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. 20. 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;

* * *

* * * Allocation of Expenses * * *

Sec. 21. 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 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. 22. 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 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. 23. 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.

* * * Prior Authorizations * * *

Sec. 24. 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 system savings 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. 25. 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~~ House Committee on ~~health care~~ Health Care and the ~~senate committee~~ Senate Committee on ~~health and welfare~~ Health and Welfare. 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, an update regarding implementation of any prior authorization pilot programs under section 9377a of this title, 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. 26. 18 V.S.A. § 9414b is added to read:

§ 9414b. ANNUAL REPORTING BY THE DEPARTMENT OF VERMONT HEALTH ACCESS

(a) The Department of Vermont Health Access shall annually report the following information, in plain language, to the House Committee on Health Care and the Senate Committee on Health and Welfare, as well as posting the information on its website:

(1) the total number of Vermont lives covered by Medicaid;

(2) the total number of claims submitted to the Department for services provided to Medicaid beneficiaries;

(3) the total number of claims denied by the Department;

(4) the total number of denials of service by the Department at the preauthorization level, the total number of denials that were appealed, and of those, the total number overturned;

(5) the total number of adverse determinations made by the Department;

(6) the total number of claims denied by the Department because the service was experimental, investigational, or an off-label use of a drug; was not medically necessary; or involved access to a provider that is inconsistent with the limitations imposed by Medicaid;

(7) the total number of claims denied by the Department as duplicate claims, as coding errors, or for services or providers not covered;

(8) the Department's legal expenses related to claims or service denials during the preceding year; and

(9) the effects of the Department's policy of allowing automatic approval of certain prior authorizations on the number of requests for imaging, medical procedures, prescription drugs, and home care.

(b) The Department may indicate the extent of overlap or duplication in reporting the information described in subsection (a) of this section.

(c) To the extent practicable, the Department shall model its report on the standardized form created by the Department of Financial Regulation for use by health insurers under subsection 9414a(c) of this title.

(d) The Department of Financial Regulation shall post on its website, in the same location as the forms posted under subdivision 9414a(d)(1) of this title, a link to the information reported by the Department of Vermont Health Access under subsection (a) of this section.

Sec. 27. 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;

~~(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;

* * * Additional Provisions * * *

Sec. 28. REPEAL

8 V.S.A. § 4089w (Health Care Ombudsman) is repealed.

Sec. 29. APPROPRIATION

The sum of $250,000.00 is appropriated from the Consumer Assistance Assessment Fund established by 18 V.S.A. § 9607 to the Agency of Administration in fiscal year 2014 for the purposes of a contract with Vermont Legal Aid to carry out the duties of the Office of the Health Care Advocate established in 18 V.S.A. chapter 229.

Sec. 30. APPLICABILITY AND EFFECTIVE DATES

(a) Secs. 1–12 (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. 13–20 (Office of the Health Care Advocate) shall take effect on January 1, 2014.

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

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE