

1 TO THE HOUSE OF REPRESENTATIVES:

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

7 * * * Health Insurance Rate Review * * *

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

9 § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

10 (a)(1) No policy of health insurance or certificate under a policy filed by an
11 insurer offering health insurance as defined in subdivision 3301(a)(2) of this
12 title, a nonprofit hospital or medical service corporation, health maintenance
13 organization, or a managed care organization and not exempted by subdivision
14 3368(a)(4) of this title shall be delivered or issued for delivery in this ~~state~~
15 State, nor shall any endorsement, rider, or application which becomes a part of
16 any such policy be used, until:

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

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

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

14 ~~(B)~~ The Green Mountain Care board Board shall review rate requests
15 ~~forwarded by the commissioner pursuant to subdivision (A) of this subdivision~~
16 ~~(2) and shall approve, modify, or disapprove a rate request within 30 90~~
17 ~~calendar days of receipt of the commissioner's recommendation or, in the~~
18 ~~absence of a recommendation from the commissioner, the expiration of the~~
19 ~~30-day period following the department's receipt of the completed application.~~
20 ~~In the event that the board does not approve or disapprove a rate within 30~~
21 ~~days, the board shall be deemed to have approved the rate request after receipt~~

1 of an initial rate filing from an insurer. If an insurer fails to provide necessary
2 materials or other information to the Board in a timely manner, the Board may
3 extend its review for a reasonable additional period of time, not to exceed 30
4 calendar days.

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

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

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

1 (b) ~~The commissioner may, after a hearing of which at least 20 days²~~
2 ~~written notice has been given to the insurer using such form, premium rate, or~~
3 ~~rule, withdraw approval on any of the grounds stated in this section. For~~
4 ~~premium rates, such withdrawal may occur at any time after applying the~~
5 ~~decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C)~~
6 ~~of this section. Disapproval pursuant to this subsection shall be effected by~~
7 ~~written order of the commissioner which shall state the ground for disapproval~~
8 ~~and the date, not less than 30 days after such hearing when the withdrawal of~~
9 ~~approval shall become effective.~~

10 (e) In conjunction with a rate filing required by subsection (a) of this
11 section, an insurer shall file a plain language summary of ~~any requested rate~~
12 ~~increase of five percent or greater. If, during the plan year, the insurer files for~~
13 ~~rate increases that are cumulatively five percent or greater, the insurer shall file~~
14 ~~a summary applicable to the cumulative rate increase~~ the proposed rate. All
15 summaries shall include a brief justification of any rate increase requested, the
16 information that the Secretary of the U.S. Department of Health and Human
17 Services (HHS) requires for rate increases over 10 percent, and any other
18 information required by the ~~commissioner~~ Board. The plain language
19 summary shall be in the format required by the Secretary of HHS pursuant to
20 the Patient Protection and Affordable Care Act of 2010, Public Law 111-148,
21 as amended by the Health Care and Education Reconciliation Act of 2010,

1 Public Law 111-152, and shall include notification of the public comment
2 period established in subsection ~~(d)~~(c) of this section. In addition, the insurer
3 shall post the summaries on its website.

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

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

13 (B) The ~~department~~ Board shall provide an electronic mechanism for
14 the public to comment on ~~proposed rate increases over five percent~~ all rate
15 filings. ~~The public shall have 21 days from the posting of the summaries and~~
16 ~~filings to provide~~ Board shall accept public comment on each rate filing from
17 the date on which the Board posts the rate filing on its website pursuant to
18 subdivision (A) of this subdivision (2) until 15 calendar days after the Board
19 posts on its website the analyses and opinions of the Department of Financial
20 Regulation and of the Board's consulting actuary, if any, as required by
21 subsection (d) of this section. The ~~department~~ Board shall review and consider

1 the public comments prior to ~~submitting the policy or rate for the Green~~
2 ~~Mountain Care board's approval pursuant to subsection (a) of this section.~~ The
3 department shall provide the Green Mountain Care board with the public
4 comments for its consideration in approving any rates issuing its decision.

5 (3)(A) In addition to the public comment provisions set forth in this
6 subsection, a consumer representative acting on behalf of health insurance
7 consumers in this State the Office of the Health Care Advocate established
8 in 18 V.S.A. chapter 229 may, within 30 calendar days after the Board
9 receives an insurer's rate request pursuant to this section, submit to the Board,
10 in writing, suggested questions regarding the filing for the Board to provide
11 to its to the insurer and to the Board's contracting actuary, if any.

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

16 (e)(d)(1) No later than 60 calendar days after receiving an insurer's rate
17 request pursuant to this section, the Green Mountain Care Board shall make
18 available to the public the insurer's rate filing, the Department's analysis and
19 opinion of the effect of the proposed rate on the insurer's solvency, and the
20 analysis and opinion of the rate filing by the Board's contracting actuary,
21 if any.

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

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

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

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

11 (e) ~~Thirty~~ Within 30 calendar days after making the rate filing and
12 analysis available to the public pursuant to subsection (d) of this section, the
13 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~~s~~, the
19 Office of the Health Care Advocate, ~~Health Care Ombudsman; the~~
20 consumer representative, if such person is not employed by the Health
21 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~~ **Office of the Health Care**
13 **Advocate**, and any member of the public with party status, as defined by the
14 Board by rule, may appeal a decision of the Board approving, modifying, or
15 disapproving the insurer’s proposed rate to the 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~~
13 ~~18 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. § 9381 is amended to read:

12 § 9381. APPEALS

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

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

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

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

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

16 Sec. 12. 33 V.S.A. § 1811(j) is amended to read:

17 (j) The ~~commissioner~~ Commissioner or the Green Mountain Care Board
18 established in 18 V.S.A. chapter 220, as appropriate, shall disapprove any rates
19 filed by any registered carrier, whether initial or revised, for insurance policies
20 unless the anticipated medical loss ratios for the entire period for which rates

1 are computed are at least 80 percent, as required by the ~~Patient Protection and~~
2 ~~Affordable Care Act (Public Law 111-148).~~

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

4 **Sec. 13.** 18 V.S.A. chapter 229 is added to read:

5 CHAPTER 229. OFFICE OF THE HEALTH CARE ADVOCATE

6 § 9601. DEFINITIONS

7 As used in this chapter:

8 (1) “Green Mountain Care Board” or “Board” means the Board
9 established in chapter 220 of this title.

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

14 (3) “Health insurer” shall have the same meaning as in section 9402 of
15 this title.

16 § 9602. OFFICE OF THE HEALTH CARE ADVOCATE; COMPOSITION

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

20 (b) The Office shall be administered by the Chief Health Care Advocate,
21 who shall be an individual with expertise and experience in the fields of health

1 care and advocacy. The Advocate may employ legal counsel, administrative
2 staff, and other employees and contractors as needed to carry out the duties of
3 the Office.

4 § 9603. DUTIES AND AUTHORITY

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

6 (1) Assist health insurance consumers with health insurance plan
7 selection by providing information, referrals, and assistance to individuals and
8 employers with not more than 10 full-time equivalent employees about means
9 of obtaining health insurance coverage and services. The Office shall accept
10 referrals from the Vermont Health Benefit Exchange and Exchange navigators
11 created pursuant to 33 V.S.A. chapter 18, subchapter 1, to assist consumers
12 experiencing problems related to the Exchange.

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

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

19 (4) Identify, investigate, and resolve complaints on behalf of individual
20 health insurance consumers and employers with not more than 10 full-time

1 equivalent employees who purchase insurance for their employees, and assist
2 those consumers with filing and pursuit of complaints and appeals.

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

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

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

11 ~~(8) Represent the interests of the people of the state in all cases~~
12 ~~requiring a hearing before the Green Mountain Care Board established in~~
13 ~~chapter 220 of this title.~~

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

16 (10) Promote the development of citizen and consumer organizations.

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

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

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

2 **(1) Bring proceedings on its own motion before the Green Mountain**
3 **Care Board with respect to any matter within the Board’s jurisdiction.**

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

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

10 **(4) Represent the interests of the people of the state in all cases**
11 **requiring a hearing before the Green Mountain Care Board established in**
12 **chapter 220 of this title.**

13 **(5) Adopt policies and procedures necessary to carry out the provisions**
14 **of this chapter.**

15 **(6) Take any other action necessary to fulfill the purposes of this**
16 **chapter.**

17 **(c) The Office of the Health Care Advocate shall be able to speak on behalf**
18 **of the interests of health care and health insurance consumers and to carry out**
19 **all duties prescribed in this chapter without being subject to any disciplinary or**
20 **retaliatory action; provided, however, that nothing in this subsection shall limit**

1 the authority of the Director of Health Care Reform to enforce the terms of the
2 contract.

3 § 9604. DUTIES OF STATE AGENCIES

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

8 § 9605. CONFIDENTIALITY

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

14 § 9606. CONFLICTS OF INTEREST

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

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

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

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

7 (4) receives or has the right to receive, directly or indirectly,
8 remuneration under a compensation arrangement with a health care facility,
9 health insurer, or health care provider.

10 § 9607. CONSUMER ASSISTANCE ~~SURCHARGE~~ ASSESSMENT

11 (a) The premium for each health insurance policy issued in this state shall
12 include a monthly consumer assistance ~~surecharge~~ assessment of \$0.50 per
13 covered life to fund the activities of the Office of the Health Care Advocate.
14 Each health insurer shall remit the ~~surecharges~~ assessments collected during
15 the preceding calendar quarter to the Commissioner of Financial Regulation by
16 July 15, October 15, January 15, and April 15 of each year.

17 (b) There is established pursuant to 32 V.S.A. chapter 7, subchapter 5
18 a special fund called the “Consumer Assistance Assessment Fund” into
19 which shall be deposited the funds collected under this section. The fund
20 shall be administered by the Secretary of Administration and

1 **disbursements are authorized to fund the activities of the Office of the**
2 **Health Care Advocate as appropriated by the General Assembly.**

3 (c) As used in this section:

4 (1) "Health insurance" means any group or individual health care benefit
5 policy, contract, or other health benefit plan offered, issued, renewed, or
6 administered by any health insurer, including any health care benefit plan
7 offered, issued, renewed, or administered by any health insurance company,
8 any nonprofit hospital and medical service corporation, or any managed care
9 organization as defined in 18 V.S.A. § 9402. The term includes comprehensive
10 major medical policies, contracts, or plans but does not include Medicaid,
11 ~~VHAP~~, or any other state health care assistance program financed in whole or
12 in part through a federal program. The term does not include policies issued for
13 specified disease, accident, injury, hospital indemnity, dental care, long-term
14 care, disability income, or other limited benefit health insurance policies.

15 (2) "Health insurer" means any person who offers, issues, renews, or
16 administers a health insurance policy, contract, or other health benefit plan in
17 this state and includes third-party administrators or pharmacy benefit managers
18 who provide administrative services only for a health benefit plan offering
19 coverage in this state. The term does not include a third-party administrator or
20 pharmacy benefit manager to the extent that a health insurer has collected and
21 remitted the surcharges which would otherwise be imposed on the covered

1 lives attributed to the third-party administrator or pharmacy benefit manager.

2 The term also does not include a health insurer with a monthly average of

3 fewer than 200 Vermont insured lives.

4 Sec. **14.** 18 V.S.A. § 9374(f) is amended to read:

5 (f) In carrying out its duties pursuant to this chapter, the ~~board~~ Board shall

6 seek ~~the advice of the state health care ombudsman established in 8 V.S.A.~~

7 ~~§ 4089w~~ from the Office of the Health Care Advocate. The ~~state health care~~

8 ~~ombudsman~~ Office shall advise the ~~board~~ Board regarding the policies,

9 procedures, and rules established pursuant to this chapter. The ~~ombudsman~~

10 Office shall represent the interests of Vermont patients and Vermont

11 consumers of health insurance and may suggest policies, procedures, or rules

12 to the ~~board~~ Board in order to protect patients' and consumers' interests.

13 Sec. **15.** 18 V.S.A. § 9377(e) is amended to read:

14 (e) The ~~board~~ Board or designee shall convene a broad-based group of

15 stakeholders, including health care professionals who provide health services,

16 health insurers, professional organizations, community and nonprofit groups,

17 consumers, businesses, school districts, the ~~state health care ombudsman~~

18 Office of the Health Care Advocate, and state and local governments, to advise

19 the ~~board~~ Board in developing and implementing the pilot projects and to

20 advise the Green Mountain Care ~~board~~ Board in setting overall policy goals.

21 Sec. **16.** 18 V.S.A. § 9410(a)(2) is amended to read:

1 (9) The ~~health care ombudsman's office~~ Office of the Health Care
2 Advocate established under ~~8 V.S.A. chapter 107, subchapter 1A~~ chapter 229
3 of this title or, in the case of nursing homes, the ~~long term care ombudsman's~~
4 ~~office~~ Long-Term Care Ombudsman's Office established under 33 V.S.A. §
5 7502; is authorized but not required to participate in any administrative or
6 judicial review of an application under this subchapter and shall be considered
7 an interested party in such proceedings upon filing a notice of intervention
8 with the ~~board~~ Board.

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

10 (b) In addition to all other sanctions, if any person offers or develops any
11 new health care project without first having been issued a certificate of need or
12 certificate of exemption ~~therefore~~ for the project, or violates any other
13 provision of this subchapter or any lawful rule ~~or regulation promulgated~~
14 ~~thereunder~~ adopted pursuant to this subchapter, the ~~board~~ Board, the
15 ~~commissioner~~ Commissioner, the ~~state health care ombudsman~~ Office of the
16 Health Care Advocate, the ~~state long term care ombudsman~~ State Long-Term
17 Care Ombudsman, and health care providers and consumers located in the state
18 shall have standing to maintain a civil action in the superior court of the county
19 ~~wherein~~ in which such alleged violation has occurred, or ~~wherein~~ in which
20 such person may be found, to enjoin, restrain, or prevent such violation. Upon
21 written request by the ~~board~~ Board, it shall be the duty of the ~~attorney general~~

1 ~~of the state~~ Vermont Attorney General to furnish appropriate legal services and
2 to prosecute an action for injunctive relief to an appropriate conclusion, which
3 shall not be reimbursed under subdivision (a)(2) of this ~~subsection~~ section.

4 Sec. 19. 33 V.S.A. § 1805 is amended to read:

5 § 1805. DUTIES AND RESPONSIBILITIES

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

9 * * *

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

14 * * *

15 Sec. 20. 33 V.S.A. § 1807(b) is amended to read:

16 (b) Navigators shall have the following duties:

17 * * *

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

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* * * 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

1 coverage, which for the purposes of this section shall include major medical,
2 comprehensive medical, hospital or surgical coverage, and comprehensive
3 health care services plans, but shall not include long-term care or limited
4 benefits, disability, credit or stop loss, or excess loss insurance coverage.

5 Sec. 22. 18 V.S.A. § 9415 is amended to read:

6 § 9415. ALLOCATION OF EXPENSES

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

11 (1) 40 percent by the ~~state~~ State from state monies;₂

12 (2) 15 percent by the hospitals;₂

13 (3) 15 percent by nonprofit hospital and medical service corporations
14 licensed under 8 V.S.A. chapter 123 or 125;₂

15 (4) 15 percent by health insurance companies licensed under 8 V.S.A.
16 chapter 101;₂ and

17 (5) 15 percent by health maintenance organizations licensed under
18 8 V.S.A. chapter 139.

19 (b) The Commissioner may determine the scope of the incurred expenses to
20 be allocated pursuant to the formula set forth in subsection (a) of this section if,

1 in the Commissioner's discretion, the expenses to be allocated are in the best
2 interests of the regulated entities and of the State.

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

9 **Sec. 23. BILL-BACK REPORT**

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

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

20 * * * Additional Provisions * * *

21 **Sec. 24. REPEAL**

1 8 V.S.A. § 4089w (Health Care Ombudsman) is repealed.

2 **Sec. 25. APPROPRIATION**

3 **Up to the full amount of available funds in the Consumer Assistance**
4 **Assessment Fund established by 18 V.S.A. § 9607 is appropriated to the**
5 **Agency of Appropriation on or before January 1, 2014 for the purposes of**
6 **a contract with Health Care Ombudsman Project at Vermont Legal Aid**
7 **to carry out the duties of the Office of the Health Care Advocate**
8 **established in 18 V.S.A. chapter 229.**

9 **Sec. 26. APPLICABILITY AND EFFECTIVE DATES**

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

16 **(b) Secs. 13-20 (Office of the Health Care Advocate) and 21-23**
17 (allocation of expenses) of this act and this section shall take effect on July 1,
18 2013.

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20
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1 (Committee vote: _____)

2

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Representative _____

4

FOR THE COMMITTEE