Section by Section Summary of S.152, An act relating to the Green Mountain Care Board's rate review authority - *As amended by the House Health Care Committee*
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Sec. 1. Rate review process

- Moves all rate review for major medical insurance policies to the Green Mountain Care Board (GMCB) to replace the current two-step process, which involves a recommendation from the Commissioner of the Department of Financial Regulation (DFR) to the GMCB
- Gives GMCB 90 calendar days to approve, modify, or disapprove a rate request
- DFR must provide the GMCB with an analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves
- Requires an insurer to file a plain language summary, and provides an opportunity for public comment, on all proposed rates, not just rate increases of 5 percent or more as under current law
- GMCB must establish a mechanism by which members of the public can request automatic notification every time a proposed rate is filed with the GMCB
- Office of the Health Care Advocate (HCA) may submit questions about a rate filing to the insurer and to GMCB's actuary
- HCA can submit written comments to the GMCB, which the GMCB must post on its website and consider before issuing its decision
- Within 60 days after receiving a rate request, the GMCB must make publicly available the rate filing, the DFR solvency analysis and opinion, and the actuary's analysis and opinion
- GMCB must post on its website:
    - all questions it poses to its actuary and the actuary's responses
    - all questions HCA poses to GMCB's actuary and the actuary's responses
    - all questions the GMCB, the actuary, DFR, or HCA poses to the insurer and the insurer's responses
- Within 30 days after making the rate filing and analyses available to the public, the GMCB must:
    - conduct a public hearing at which it calls DFR and the actuary as witnesses unless all parties agree to waive that testimony, and also provide opportunities for the insurer, HCA, and public to testify
    - at a public hearing, announce the GMCB's rate decision
    - issue the GMCB's rate decision in writing
- Insurer must notify policyholders of GMCB's decision in a timely manner
- Rates take effect on the date specified in the insurer's rate filing
- If Board has not issued its rate decision by the effective date specified in the filing, the insurer must notify its policyholders of the pending rate request and the effective date the insurer has proposed
- An insurer, HCA, and any member of the public with party status (as defined by the Board by rule) may appeal GMCB's decision to the Vermont Supreme Court
- DFR retains rate review authority over all policies other than major medical

- GMCB may establish by rule a streamlined rate review process for certain rate decisions, including proposed rates affecting only a few covered lives and proposed rates for which a de minimis increase (as defined by the Board by rule) is sought

Sec. 2. Filing fees

- Increases the fee for filing health insurance policies, contracts, forms, and rates with the Commissioner of DFR or the GMCB, as appropriate, from $50 to $150

Secs. 3 - 9. Rate review for different types of health insurers

- Makes conforming changes to reflect the revised the rate review process in the statutes for mental health carve-outs (Sec. 3), hospital service corporations (Secs. 4 - 6), medical service corporations (Secs. 7 and 8), and health maintenance organizations generally (Sec. 9)

Sec. 10. Green Mountain Care Board duties

- Makes conforming changes to the rate review process in the statute detailing the duties of the GMCB

Sec. 11. Appeals from GMCB decisions

- Amends the GMCB appeals statute to conform to the new rate review process
- Makes clear that a decision of the GMCB in a rate review case is considered a final action and may be appealed directly to the Vermont Supreme Court

Sec. 12. Plans offered through the Vermont Health Benefit Exchange

- Makes conforming changes to the rate review provisions of the law governing medical loss ratios for plans offered through the Vermont Health Benefit Exchange

Sec. 13. Office of the Health Care Advocate

- Creates the Office of the Health Care Advocate (HCA), which is modeled on the existing State Health Care Ombudsman
- Directs Agency of Administration to establish HCA by contract with a nonprofit
- Requires HCA to:
    - assist individual and small groups (employers with up to 10 FTEs) with information and assistance in getting health insurance coverage
    - assist health insurance consumers understand their insurance plan rights
    - provide information to the public and government about health insurance problems and concerns and recommendations for addressing them
    - identify, investigate, and resolve insurance complaints for individuals and small groups (employers with up to 10 FTEs)
    - provide information about individual and employer duties and responsibilities under the federal Affordable Care Act
    - analyze, monitor, and facilitate public comment on relevant laws, rules, and policies
    - suggest policies, procedures, or rules to GMCB to protect patient/consumer interests

    - promote development of citizen and consumer organizations
    - ensure time access to HCA's services
    - submit annual report to General Assembly and Governor
- Allows HCA to:
    - review health insurance records with the patient's consent
    - pursue remedies on behalf of health insurance consumers
    - represent interests of the State in cases requiring hearing before GMCB
    - adopt necessary policies and procedures
    - take any other necessary action
- Specifies that HCA may speak on behalf of consumers and carry out its duties without being subject to disciplinary or retaliatory action (except that HCA is still bound by the terms of the contract with the Agency of Administration)
- Requires state agencies to comply with reasonable requests from the HCA
- Imposes on health insurance premiums a monthly consumer assistance assessment of $0.22 per covered life to fund the HCA
    - Insurers will collect the assessment and remit it to DFR quarterly
    - DFR will deposit the funds in the Consumer Assistance Assessment Fund
    - Insurers and Exchange must clearly communicate consumer assistance assessment to all applicants and enrollees

Secs. 14 - 20. References to Office of the Health Care Advocate

- Deletes references to the Office of the Health Care Ombudsman throughout the statutes and replaces with the Office of the Health Care Advocate

Secs. 21 - 23. Bill-back allocation

- Provides flexibility to GMCB (Sec. 21) and the Commissioner of DFR (Sec. 22) to determine the scope of expenses to be allocated using bill-back based on what the GMCB/Commissioner believes to be in the best interests of the regulated entities and the State
- Sec. 23 requires GMCB and DFR to report annually the total amount of expenses eligible for bill-back during the previous state fiscal year and the total amount of expenses that were actually billed back to the regulated entities during that year

Sec. 24. Prior authorization pilot program

- Directs the GMCB to create one or more pilot programs designed to measure the effects of eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care
- Requires the GMCB to provide an update on its prior authorization pilot program(s) as part of its annual report

Sec. 25. GMCB annual report

- Makes a conforming change to reflect the requirement in Sec. 24 that the GMCB include an update on its prior authorization pilot program(s) in its annual report

Sec. 26. DVHA annual prior authorization report

- Directs DVHA to report annually to the committees of jurisdiction, and publish on its website, information similar to what health insurers are required to report annually, including the total number of claims for services, the number of denials of services at the preauthorization level, and the effects of the Department of Vermont Health Access's (DVHA) "goldcarding" program, which grants automatic preauthorization approval in certain cases
- Directs DFR to post DVHA's report on the DFR website in the same location as the reports made by other health insurers

Sec. 27. Health insurer annual reports

- Clarifies that health insurers should include in their annual reports on prior authorizations the total number of denials of service at the preauthorization level

Sec. 28. Rate filings for 2014

- Directs DFR and GMCB, when reviewing rates filed for the 2014 calendar year, to take into account the consumer assistance assessment established in Sec. 13

Sec. 29. Repeal

- Repeals the Office of the Health Care Ombudsman

Sec. 30. Appropriation

- Appropriates $250,000 from the Consumer Assistance Assessment Fund to the Agency of Administration in FY 2014 for a contract with Vermont Legal Aid to carry out the duties of the Office of the Health Care Advocate

Sec. 31. Applicability and effective dates

- Rate review provisions take effect on January 1, 2014, except that the GMCB and DFR can amend their rules and take other actions necessary to ensure that the new rate review process with be operational by January 1, 2014
- The Office of the Health Care Advocate provisions take effect on January 1, 2014
- Sec. 28, on 2014 rate filings, takes effect on passage
- All other provisions take effect on July 1, 2013