**H.137 – language regarding Medicare supplemental insurance policies**

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

§ 4062b. MEDICARE ~~SUPPLEMENTAL HEALTH~~ SUPPLEMENT INSURANCE

(a) Within five days ~~of~~ after receiving a request for approval of any composite average rate increase in excess of ~~three~~ 10 percent, or any other coverage changes ~~which~~ that the Commissioner determines will have a comparable impact on cost or availability of coverage for a Medicare ~~supplemental~~ supplement insurance policy issued by any ~~group or nongroup~~ health insurance company, hospital or medical service organization, or health maintenance organization, with 5,000 or more total lives in the Vermont Medicare supplement insurance market, the Commissioner shall notify the Department of Disabilities, Aging, and Independent Living and the Office of the Health Care Advocate of the proposed premium increase. A composite average rate is the enrollment-weighted average rate increase of all plans offered by a carrier.

(b) Within five days after receiving notification pursuant to subsection (a) of this section, the Department of Disabilities, Aging, and Independent Living shall inform the members of the Advisory Board established pursuant to 33 V.S.A. § 505 of the proposed premium increase.

(c)(1) The Commissioner shall not approve any request to increase Medicare ~~supplemental~~ supplement insurance premium rates unless the amount of the rate increase complies with the statutory standards for approval under sections 4062, 4513, 4584, and 5104 of this title. Any approved rate increase shall not be based on an unreasonable change in loss ratio from the previous year, unless the Commissioner makes written findings that such change is necessary to prevent a substantial adverse

impact on the financial condition of the insurer. In acting on such rate increase requests, the Commissioner may deny the request, approve the rate increase as requested, or approve a rate increase in an amount different from the increase requested. A decision by the Commissioner other than an approval of the rate requested may be appealed by the insurer, provided that the burden of proof shall be on the insurer to show that the approved rate does not meet the statutory standards established under this subsection.

(2) Before acting on the rate increase requested, the Commissioner may make such examination or investigation as ~~he or she~~ the Commissioner deems necessary~~,~~ ~~including where applicable the review process set forth in subdivision (3) of this subsection~~.

(3) ~~In reviewing any Medicare supplement rate increase for which an independent analysis has been performed pursuant to 33 V.S.A. § 6706 and wherein the carrier's requested composite average increase, the independent expert's recommended composite average rate increase, or the Department actuary's recommended composite average rate increase differ by two percentage points or more~~ For any filing in which the requested composite average rate increase exceeds 10 percent and impacts 5,000 or more covered lives in Vermont, the Commissioner shall solicit public comment and may hold a public hearing ~~where the insurer, the Department's actuary, the independent expert, any intervenor, and the public will have the opportunity to present written and oral testimony and will be available to answer questions of the Commissioner and those present~~ in accordance with the Department of Financial Regulation's applicable rules regarding administrative procedures. ~~The~~

~~hearing shall be noticed and held at a time and place so as to facilitate public participation, and shall be recorded and become part of the record before the Commissioner.~~ In the Commissioner's discretion, the hearing may be conducted through ~~interactive television~~ a designated electronic meeting platform. ~~If the carrier's requested composite average increase, the independent expert's recommended composite average increase, or the Department actuary's recommended composite average increase differs by less than two percentage points, the Department and the parties shall confer by conference call, or by any other available media, to review the rate requests and recommendations. However, a public hearing may be held at the Commissioner's discretion for good cause shown.~~

(4) ~~In any review held in accordance with this subsection, the Commissioner shall permit intervention by any person that the Commissioner determines will materially advance the interests of the insured individuals. The intervenor shall have access to, and may use the information of the independent expert appointed under 33 V.S.A. § 6706. The reasonable and necessary cost of intervention as determined by the Commissioner shall be paid by the affected policyholders or certificate holders. The maximum payment shall be $2,500.00 except when waived by the Commissioner for good cause shown. The $2,500.00 maximum amount may be adjusted to reflect, at the Commissioner's discretion, appropriate inflation factors.~~ [Repealed.]

(5) Nonproprietary, relevant information in any Medicare supplement rate filing, including any analysis by the Department's actuary ~~and the independent expert~~, shall be made available to the public upon request.

(d) For a Medicare supplement insurance policy with an effective date of January 1, the insurer shall file its premium rate request pursuant to this section not later than July 1 of the preceding year. For a Medicare supplement insurance policy with an effective date other than January 1, the insurer shall file its rate request pursuant to this section not later than six months prior to the effective date of the policy.

Sec. B. REPEAL

33 V.S.A. § 6706 (Medicare supplement insurance; independent analysis) is repealed.