H.165

Introduced by Representative Poirier of Barre City

Referred to Committee on

Date:

Subject: Health; health insurance; BISHCA; rate review; consumer protection

Statement of purpose: This bill proposes to expand the role of the health care ombudsman, fund consumer protection activities, and make changes to the health insurance rate review process.

An act relating to health insurance rates and consumer protection

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 8 V.S.A. § 4089w is amended to read:

§ 4089w. OFFICE OF HEALTH CARE OMBUDSMAN

(a) The department shall establish the office of the health care ombudsman by contract with any nonprofit organization <u>to represent the interests of Vermont consumers of health insurance</u>. The office shall be administered by the state health care ombudsman, who shall be an individual with expertise and experience in the fields of health care and advocacy.

(b) The health care ombudsman office shall:

* * *

(9) Submit to the general assembly and to 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 year and recommendations for improving consumer protection with respect to health care and health insurance.

(c) The state health care ombudsman may:

* * *

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

(A) intervening, as a matter of right, in any administrative proceeding pursuant to this title or chapter 221 of Title 18, relating to health insurance and managed care organizations; and

(B) commencing or intervening in any judicial proceeding to represent the interests of the public relating to managed care or health insurance.

(4) Inquire into the policies, practices, and activities of health insurers and managed care organizations to determine whether those policies, practices, and activities are in the best interests of Vermont residents. Any managed care organization or health insurer licensed to do business in this state shall disclose to the ombudsman all requested information except to the extent that such information is deemed confidential by law.

(5) Recommend to the governor, the general assembly, and other agencies and instrumentalities of the state actions designed to enhance the interests of health insurance consumers.

(6) Delegate to employees and contractors of the ombudsman any part of the state ombudsman's authority.

~~(5)~~(7) Adopt policies and procedures necessary to carry out the provisions of this subchapter.

~~(6)~~(8) Take any other actions necessary to ~~fulfil~~ fulfill the purposes of this subchapter.

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Sec. 2. 8 V.S.A. § 4090 is added to read:

§ 4090. VERMONT HEALTH CARE SUPERVISORY FUND

(a) The Vermont health care supervisory fund is established in the state treasury as a special fund for the purpose of supporting consumer protection activities by the division of health care administration within the department of banking, insurance, securities, and health care administration. One hundred percent of the fund shall be disbursed to support the division's consumer protection activities, including administrative and operational expenses, employee salary and benefits, and contractual services and associated expenses, less any disbursements related to the administration of the fund. Disbursements from the fund shall be made by the state treasurer on warrants

drawn by the commissioner of finance and management after receipt of proper documentation regarding services rendered or expenses incurred. The commissioner of finance and management may anticipate receipts to the fund and issue warrants thereon.

(b) Into the fund shall be deposited assessments collected pursuant to subsection (c) of this section. The fund shall be administered pursuant to subchapter 5 of chapter 7 of Title 32, except that interest earned on the fund and any remaining balance shall be retained in the fund.

(c)(1) The Vermont health care supervisory fund shall be funded by an assessment of $1.50 for each life covered by a health insurance company, nonprofit hospital and medical service corporation, health maintenance organization or other health benefit plan, managed care organization, supplemental Medicare policy, or any policy established pursuant to section 4079 of this title.

(2) No assessment shall be required pursuant to this section for lives insured under policies for specified diseases, accidents, injuries, hospital indemnity, dental care, long-term care, disability income, or other limited benefits.

(3) The assessment shall be paid by the health insurer or managed care organization on or before October 1 of each year, accompanied by a form

prescribed by the commissioner of banking, insurance, securities, and health care administration.

(4) The assessment shall be based on the total number of the health insurer's or managed care organization's covered lives as of December 31 of the preceding year. For individual coverage, covered lives shall include Vermont residents, and for group policies, covered lives shall be all lives covered by a policy for which the purchaser is located in Vermont.

(5) In the event that a health insurer or managed care organization fails to pay the required assessment by October 1, in addition to any other sanctions available to the commissioner for violations of this title and Tilte 18, the commissioner may collect as assessment by civil action. In a civil collection action, the commissioner may assess costs of collection, reasonable attorney's fees, and interest at the rate of 12 percent per annum from the date of delinquency.

Sec. 3. REPORT

No later than February 15, 2013, the commissioner of banking, insurance, securities, and health care administration shall report to the house committees on health care and on human services and the senate committee on health and welfare regarding the amount of moneys in the health care supervisory fund, the establishment and accomplishments of the positions, and the activities of the division of health care administration in protecting consumers.

Sec. 4. TRANSFER OF POSITIONS; POSITIONS AUTHORIZED

In fiscal year 2012, the following positions shall be transferred and converted from areas of government to be determined by the secretary of administration to fill three positions authorized in the department of banking, insurance, securities, and health care administration as follows:

(1) One information and education specialist or representative;

(2) One staff investigator; and

(3) One level III staff attorney.

Sec. 5. APPROPRIATION

The sum of $400,000.00 is appropriated to the Vermont health care supervisory fund from the general fund in fiscal year 2012 to carry out the provisions of this act, including $150,000.00 for the contract for the health care ombudsman pursuant to 8 V.S.A. § 4089w.

* * * Health Insurance Rate Review * * *

Sec. 6. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a) Rate and form filings. No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form, premium rates, and rules for the classification of risks pertaining

thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; and the filing has been reviewed and received written approval by the commissioner; nor shall any such form, premium rate, or rule be so used until the expiration of 30 days after having been filed, unless the commissioner shall sooner give his or her written approval thereto. The commissioner shall notify in writing the insurer which has filed any such form, premium rate or rule if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer. In all other cases, the commissioner shall give his or her approval. After the expiration of such 30 days from the filing of any such form, premium rate or rule, or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 ~~days~~ 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. Such disapproval 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.

(b) Filings to be made electronically. All rate and form filings made by a health insurer must be filed electronically for approval with the department of banking, insurance, securities, and health care administration.

(1) The commissioner shall:

(A) Post the entire rate filing, including the summary and all required information, on the department's website within five days of receipt of the rate filing;

(B) Post links on the department's homepage to a webpage on which rate filings and summaries can be found;

(C) Label all rate filings and summaries, by the name of the insurer, type of policy, and the filing date of the proposed rate; and

(D) Post instructions and plain language explanatory material to make it easy to find a rate filing in the database, when a searchable database is used to publicly post rate filings.

(2) Any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, is subject to this section.

(3) The department of banking, insurance, securities, and health care administration shall adopt rules necessary to carry out the purposes of this section.

(c) Rate approval. No premium rate or request for a premium rate change shall be implemented by the health insurer prior to:

(1) Approval by the commissioner; and

(2) The receipt of written notice of the change by members as set forth in subsections (j) and (p) of this section.

(d) Approved rates guaranteed. Approved rates shall be guaranteed by the health insurer, as to the members affected by the rates, for a period not less than 12 months.

(e) Rate filing information. Every health insurance rate filing shall include sufficient information and data to allow the commissioner to consider factors set forth in subsection (n) of this section. The required rate request information shall be presented in a format to be determined by regulation by the commissioner.

(1) Within 10 days of receiving a rate filing, the commissioner shall determine whether the rate filing is complete;

(2) Failure to submit all the required information shall make the rate filing incomplete;

(3) If the rate filing is incomplete, the commissioner shall notify the insurer in writing that the filing is deficient and provide the health insurer with the opportunity to complete the filing.

(f) Rate summary and actuarial memorandum. All rate filings made by a health insurer shall include:

(1) A rate filing summary provided in a manner that informs members of the proposed rate increase and explains the reasons for the proposed rate increase;

(2) An actuarial memorandum describing the benefit plan for each product and a description of any changes to the benefit plan;

(A) The actuarial memorandum shall report:

(i) The health insurer's overall medical trend factor assumed, and also broken down by rate of price inflation and rate of utilization changes;

(ii) The medical trend for the two most recent 12-month experience periods, itemized by rate of price inflation and rate of utilization changes;

(iii) The medical trend for the two most recent 12-month experience periods, disaggregated by category of type of medical reimbursement, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, including laboratory, and radiology; medical trend for each category should be itemized by rate of price inflation and rate of utilization changes;

(iv) Information on aggregate cost increases for all hospitals within a plan network;

(v) Information on aggregate cost increases for all medical groups within a plan network.

(B) The actuarial memorandum shall explain:

(i) How the proposed rates were calculated, including a description of all assumptions, factors, calculations, and all other information pertinent to the proposed rates; and

(ii) The medical trend factors and all other factors used in developing the proposed rates.

(C) The actuarial memorandum shall identify and quantify all medical trend factors and all other factors used in developing the proposed rates.

(D) The actuarial memorandum shall include rate tables presented as determined by the commissioner.

(E) The actuarial memorandum shall show the average overall proposed rate increase, the maximum rate increase, and the minimum rate increase for each health plan subject to the proposed rate increase.

(F) The actuarial memorandum shall include the signature of the actuary and date that the qualified actuary reviewed the rate filing.

(g) Description of cost containment and quality improvement efforts. The health insurer's proposed rate increase shall explain any changes the insurer has made in its health care cost-containment efforts and quality improvement efforts since the insurer's last rate filing for the same category of health benefit

plan, including a description of any factors that relate to the commissioner's consideration of affordability under subdivisions (n)(5)(Q)(i–iv) of this section.

(h) Disclosure of expenses. A health insurer's proposed rate request shall include information to show expenses relating to:

(1) Salaries, wages, bonuses, and other compensation benefits;

(2) Broker commissions;

(3) Rent or occupancy expenses;

(4) Marketing and advertising;

(5) Federal and state lobbying expenses;

(6) All political contributions;

(7) All dues paid to trade groups that engage in lobbying or make political contributions;

(8) General office expenses, including sundries, supplies, telephone, printing, and postage;

(9) Third party administration expenses or fees or other groups' service expense or fees;

(10) Legal fees and expenses and other professional or consulting fees;

(11) Other taxes, licenses, and fees;

(12) Travel expenses; and

(13) Charitable contributions.

(i) Certificate of compliance. The health insurer's proposed rate increase shall be signed by the officers of the health insurer who exercise the functions of chief executive and chief financial officer. Each officer signing the rate request shall certify that:

(1) the representations, data, and information provided to the department to support the proposed rate request are true; and

(2) the filing complies with state statutes, rules, product standards, and filing requirements.

(j) Notice of proposed rate change and public comment period. A health insurer shall send written notice of a proposed rate change to each policyholder affected by the change on or before the date the rate filing or application is submitted to the commissioner for review. The written notice of a proposed rate change shall:

(1) State in size 16-point bold font the actual dollar amount of the proposed rate change and specific percentage by which the current premium would be increased for the policyholder;

(2) Describe in plain, understandable terms any changes in the plan design or any changes in benefits, and highlight this information in size 16-point bold font;

(3) Include mailing and website addresses and telephone numbers for the health insurer through which a person may request additional information;

(4) Provide information about public programs, including Medicaid, high risk pools, Dr. Dynasaur, VHAP, and Catamount;

(5) State that the proposed rate change is subject to approval by the department;

(6) Inform policyholders of the 30-day public comment period available under subsection (l) of this section; and

(7) Provide the website address of the department where the health insurer's rate filing can be found.

(k) Commissioner e-mail alert system. The commissioner shall:

(1) Make available an e-mail alert system in which members of the public may sign up on the department's website to receive notice of a proposed rate increase for a selected health insurer; and

(2) Send such e-mail alerts within three business days after receiving a rate filing proposing a rate change.

(l) Public comment period. Beginning on the date that a proposed rate change is posted on the department's website, the commissioner shall open a 30-day public comment period on the proposed rate filing.

(1) The commissioner shall:

(A) Allow members of the public to comment by mail and e-mail; and

(B) State prominently on the department's website information describing the public comment period that applies to proposed rate changes and how the public may submit a comment.

(2) The commissioner may create a website where members of the public may publicly post comments.

(3) The commissioner, in his or her discretion, may convene meetings around the state for the public to comment and ask questions.

(4) If a proposed rate filing is incomplete under subsection (e) of this section, the commissioner shall start a new 30-day public comment period after the commissioner has determined that the proposed rate filing is complete and the complete rate filing has been posted on the department's website.

(m) Written decision on proposed rate filing. Within three days after the close of the 30-day public comment period required under subsection (l) of this section, the commissioner shall issue a written decision with findings on the considerations enumerated in subsection (n) of this section and any other considerations taken into account, to approve, modify, or disapprove the proposed rates.

(1) If a public hearing on the proposed rate change is held under subsection (q) of this section, the commissioner may reasonably extend the time to issue a written decision with findings to approve, modify, or disapprove the proposed rate change to accommodate a hearing schedule.

(2) Upon issuing the decision on the proposed rate, the commissioner shall post his or her decision on the department's website and provide written notice to the insurer of the decision.

(n)(1) Standards for approving, modifying, or disapproving a rate filing. When making any determination on a rate filing made pursuant to this section, the commissioner shall act to:

(A) Guard the solvency of health insurers;

(B) Protect the interests of consumers of health insurance; and

(C) Encourage and direct insurers toward policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate affordability of coverage and access.

(2) Health insurance rates shall be:

(A) Actuarially sound;

(B) Reasonable, not excessive, inadequate, or unfairly discriminatory; and

(C) Based on reasonable administrative expenses.

(3) A health insurer shall have the burden to show by clear and convincing evidence that its rates comply with requirements set forth in this subsection.

(4) The commissioner shall disapprove a rate filing when the proposed rates are:

(A) Not actuarially sound;

(B) Unreasonable;

(C) Excessive;

(D) Inadequate;

(E) Unfairly discriminatory;

(F) Based on unreasonable administrative expenses;

(G) Not in the public interest; or

(H) Incomplete.

(5) In making a determination on the proposed rates in a health insurer's rate filing, the commissioner shall consider and issue findings on the following factors:

(A) Reasonableness and soundness of:

(i) Actuarial assumptions; and

(ii) Calculations, projections, and factors used by the insurer to arrive at the proposed rate change;

(B) The insurer's historical trends for medical claims;

(C) Inflation indices, such as the Consumer Price Index and medical care component of the Consumer Price Index;

(D) Reasonableness of historical and projected administrative expenses;

(E) Compliance with medical loss ratio standards in effect under federal and state law;

(F) Whether the health insurer has complied with all federal and state requirements for pooling risk and requirements for participation in risk adjustment programs in effect under federal and state law;

(G) The financial condition of the insurance company for at least the past five years, including profitability, surplus, reserves, investment income, reinsurance, dividends, and transfers of funds to affiliates or parent companies or both;

(H) Whether the proposed rate change and any contribution to surplus or profit margin included in the proposed rate change is reasonable in light of the entire surplus level of the company and additional factors in this subsection (n);

(I) The financial performance for at least the past five years, or total years in existence if less, of the block of business subject to the proposed rate change, including past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block of business;

(J) The financial performance for at least the past five years of the insurer's statewide individual market and overall business;

(K) All anticipated changes in the number of enrollees if the proposed rate is approved;

(L) All changes to covered benefits or health benefit plan design;

(M) Whether the proposed change in premium rates is necessary to maintain the solvency of the health insurer or to maintain rate stability and prevent excessive rate increases in the future;

(N) The health insurer's statement of purpose or mission in its corporate charter or mission statement;

(O) The hardship on members affected by the proposed rate change;

(P) Public comments received by the department under subsection (l) of this section;

(Q) Affordability of the insurance product or products subject to the proposed rate. The commissioner shall consider the following in assessing affordability:

(i) Price comparison to other market rates for similar products;

(ii) Efforts of the health insurer to maintain close control over its administrative costs;

(iii) Changes to the health insurer's cost-containment and quality-control efforts since the health insurer's last rate filing for the same product or products or both;

(iv) Strategies by the insurer to enhance the affordability of its products;

(v) Provider payment strategies employed to enhance cost-effective utilization of appropriate services;

(vi) Five-year rate change history for the population affected by the proposed rate; and

(vii) Constraints on affordability efforts, including:

(I) State and federal requirements;

(II) Costs of medical services over which plans have limited control;

(III) Health plan solvency requirements; and

(IV) The present financing system.

(R) The commissioner shall have the discretion to:

(i) Consider any factor that may be relevant to the commissioner's decision; and

(ii) Request from a health insurer information or data related to all factors considered by the commissioner.

(o) Closed blocks of business. Until such time as Section 1312(c) of the Patient Protection and Affordable Care Act is fully in effect in the state, a health insurer must pool experience of a closed block of business with all appropriate blocks of business that are not closed, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool. A closed block of business is a policy or group of policies which are:

(1) No longer being marketed or sold by the health insurer;

(2) Has less than 500 in force contracts in Vermont; or

(3) Has an enrollment which has dropped by more than 12.0 percent since the last rate filing.

(p) Notice of rate determination. When the commissioner makes a determination on a health insurer's rate filing, the commissioner shall send written notice of the determination to the health insurer.

(1) Upon receipt of written notice of the commissioner's approval of the proposed rates, the health insurer shall send written notice by first class mail to each policyholder and member affected by the rate approval.

(2) The health insurer's written notice to each policyholder and member affected by the rate change shall:

(A) Inform each policyholder and member in size 16-point bold font the actual dollar amount of the approved premium increase;

(B) Show the specific percentage by which the current premium will increase for the policyholder and member;

(C) Include the effective date of the new rate;

(D) Describe, in plain and understandable terms, all changes in the health policy plan design and all changes in benefits, including any reduction in benefits or changes to waivers, exclusions, or conditions, which is printed in 16-point bold font; and

(E) Provide information about public programs, including Medicaid, high risk pools, and CHIP.

(3) No approved rate shall be effective less than 60 days from a policyholder's and member's receipt of the notice required under this section.

(q) Public hearings.

(1) During the 30-day public comment period, the commissioner of banking, insurance, securities, and health care administration shall issue an order scheduling a public hearing on a proposed rate change if a written request to the commissioner for a hearing within 45 days of the opening of the public comment period is made by at least 25 consumer representatives directly affected by the proposed rate change; or by a consumer advocacy group.

(2) The commissioner may deny the hearing request only if the premium rate filing has already been deemed unreasonable or will be denied by the commissioner.

(3) A public hearing shall be scheduled if:

(A) The commissioner determines to hold a public hearing;

(B) The attorney general requests a hearing;

(C)(i) The proposed rate change exceeds an overall 10.0 percent increase; or

(ii) the proposed rate increase would result in an annual increase exceeding 10.0 percent for any health plan.

(4) The commissioner shall adopt rules for the governing of public hearings, including:

(A) Time lines for scheduling and commencing hearings; and

(B) Procedures preventing delays and continuances of public hearings without good cause.

(r) Public hearing procedure. The commissioner of banking, insurance, securities, and health care administration shall adopt rules governing public hearings on proposed rate changes.

(1) Public hearings on proposed rate changes shall be conducted by a hearing officer who shall issue a decision within 30 days of the closing of the record.

(2) The hearing officer will take judicial notice of public comments received during the public hearing and public comment period set forth in subsection (l) of this section.

(3) The commissioner shall, adopt, amend, or reject a decision by the hearing officer within ten days of the decision made by the hearing officer.

(4) For purposes of judicial review:

(A) A decision to hold a hearing is not a final order or decision; and

(B) A decision not to hold a hearing is final.

(5) The commissioner shall provide notice of the hearing not less than 14 days prior to the hearing. The notice shall:

(A) Be published, at least 14 days prior to a hearing:

(i) On the department's website; and

(ii) In a newspaper or newspapers having an aggregate general circulation throughout the state.

(B) Contain a description of the proposed rates.

(C) Provide information on opportunities for the public to provide comment on the rate proposal to the commissioner.

(6) A copy of commissioner's notice shall be sent to the health insurer.

(7) The health insurer shall provide by first class mail, at least 14 days prior to the public hearing, notice of the public hearing to members. The notice shall describe the proposed rate request.

(8) All documents, public comments, and correspondence with the department, which are submitted as part of the public hearing on a proposed rate request, are public records.

(9) The commissioner shall provide prompt and reasonable access to the records concerning any proposed rate request to the public at no charge.

(10) The records concerning all proposed rate requests shall be considered public records, which shall be posted on the department's website.

(11) The commissioner may contract with actuaries and subject matter experts or both to assist with the department's review of the proposed rate filing.

(A) The contracted actuary and other experts shall serve under the discretion of the commissioner; and

(B) The commissioner is exempt from the provisions of applicable state law regarding public bidding procedures for the purposes of entering into contracts pursuant to this subsection.

(12) Insurance companies doing health insurance business in the state shall be assessed according to a schedule of direct writing of health insurance in the state to pay for the compensation of the actuary.

(s) Intervenors. The commissioner, on timely application, shall allow any person with an interest in the outcome of a proposed rate filing to intervene as a party to that proceeding.

(1) Policyholders, insured members, consumer advocates, and community representatives shall be considered persons with an interest.

(2) Any person whose interest is determined to be affected may present evidence, examine and cross-examine witnesses, offer oral and written argument, and conduct discovery proceedings in the same manner as is allowed in Vermont state court.

(3) The specific provisions of this act shall control in the event of a conflict with requirements of state administrative law.

(4) This subsection does not limit the power of the commissioner to consolidate parties with similar interests for the purpose of intervention.

(5) Insurers doing health insurance business in the state shall be assessed according to a schedule of direct writing of insurance in the state to pay for intervenor's fees and expenses.

(t) Judicial review. A final action by the commissioner shall be subject to judicial review by the Vermont state court in the county where the services are rendered at the initiation of the insurer or any person that is a party to a proceeding under this act.

* * * SMALL GROUP HEALTH BENEFIT PLANS * * *

Sec. 2. 8 V.S.A. § 4080a(k) is amended to read:

(k) A registered small group carrier shall guarantee the rates on a group plan for a minimum of ~~six~~ 12 months.

* * * CATAMOUNT HEALTH * * *

Sec. 3. 8 V.S.A. § 4080f(g) is amended to read:

(g)(1) Approval of rates and forms for Catamount Health shall be pursuant to the process established herein ~~and~~, rules adopted pursuant to this section, and the requirements of section 4062 of this chapter. Premium rates shall be actuarially determined considering differences in the demographics of the

populations and the different levels and methods of reimbursement for health care professionals.

(2) No rate or form shall be approved if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state. A rate shall be approved if it is sufficient not to threaten the financial safety and soundness of the insurer, reflects efficient and economical management, provides Catamount Health at the most reasonable price consistent with actuarial review, is not unfairly discriminatory, ~~and~~ complies with the other requirements of this section, and complies with the requirements of section 4062 of this chapter.

Sec. 4. 8 V.S.A. § 4080f(m) is amended to read:

(m) A letter of intent, proposed rates, and proposed forms shall be filed consistent with the requirements of this section ~~and~~, the rules adopted pursuant to this section, and requirements of section 4062 of this chapter.

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Sec. 10. EFFECTIVE DATE

This act shall take effect on October 1, 2011.