

1 S.255

2 Introduced by Senators Ayer and Lyons

3 Referred to Committee on

4 Date:

5 Subject: Health; health insurance; Department of Financial Regulation

6 Statement of purpose of bill as introduced: This bill proposes to require
7 hospitals to provide information to the public about their community health
8 needs and to allow public participation in the community health needs
9 assessment process. It would establish a statewide comparative hospital
10 quality report and modify the regulation of managed care organizations. The
11 bill would also expand the information health insurers must report annually to
12 include detailed information regarding claims processing, denials, grievances,
13 and provider satisfaction, and it would require insurers to post all of the
14 information on their websites.

15 An act relating to regulation of hospitals, health insurers, and managed care
16 organizations

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

2 Sec. 1. 18 V.S.A. § 9405a is amended to read:

3 § 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING

4 (a) Each hospital shall have a protocol for meaningful public participation
5 in its strategic planning process for identifying and addressing health care
6 needs that the hospital provides or could provide in its service area. Needs
7 identified through the process shall be integrated with the hospital's long-term
8 planning. ~~The process shall be updated as necessary to continue to be~~
9 ~~consistent with such planning and capital expenditure projections, and~~
10 ~~identified needs shall be summarized in the hospital's community report.~~ Each
11 hospital shall post on its website a description of its identified needs, strategic
12 initiatives developed to address the identified needs, annual progress on
13 implementation of the proposed initiatives, and opportunities for public
14 participation. Hospitals may meet the community health needs assessment and
15 implementation plan requirement through compliance with the relevant
16 Internal Revenue Service community health needs assessment requirements for
17 nonprofit hospitals.

18 (b) When a hospital is working on a new community health needs
19 assessment, the hospital shall post on its website information about the process
20 for developing the community needs assessment and opportunities for public
21 participation in the process.

1 Sec. 2. 18 V.S.A. § 9405b is amended to read:

2 § 9405b. HOSPITAL COMMUNITY REPORTS

3 (a) The Commissioner of Health, in consultation with representatives from
4 hospitals, other groups of health care professionals, and members of the public
5 representing patient interests, shall adopt rules establishing a ~~standard format~~
6 ~~for community reports, as well as the contents, which~~ statewide comparative
7 hospital quality report. Hospitals located outside this State which serve a
8 significant number of Vermont residents, as determined by the Commissioner
9 of Health, shall be invited to participate in the community report process
10 established by this section. The report shall include:

11 (1) Measures of quality, including process and performance measures,
12 that are valid, reliable, and useful, including comparisons to appropriate
13 national benchmarks for high quality and successful results.

14 (2) Measures of patient safety that are valid, reliable, and useful,
15 including comparisons to appropriate industry benchmarks for safety;

16 (3) Measures of hospital-acquired infections that are valid, reliable, and
17 useful, including comparisons to appropriate industry benchmarks.

18 (4) Valid, reliable, and useful information on nurse staffing, including
19 comparisons to appropriate industry benchmarks for safety. This information
20 may include system-centered measures such as skill mix, nursing care hours

1 per patient day, and other system-centered measures for which reliable industry
2 benchmarks become available.

3 (5) Measures of the hospital's financial health, including comparisons to
4 appropriate national benchmarks for efficient operation and fiscal health.

5 ~~(5)(6)~~ A summary of the hospital's budget, including revenue by source,
6 the one-year and four-year capital expenditure plans, the depreciation schedule
7 for existing facilities, and quantification of cost shifting to private payers.

8 ~~(6)(7)~~ Data that provides valid, reliable, useful, and efficient information
9 for payers and the public for the comparison of charges for higher volume
10 health care services.

11 (b) Each hospital shall publish on its website:

12 ~~(7)(1)~~ ~~The~~ the hospital's process for achieving openness, inclusiveness,
13 and meaningful public participation in its strategic planning and
14 ~~decision-making.~~ decisionmaking;

15 ~~(8)(2)~~ ~~The~~ the hospital's consumer complaint resolution process,
16 including identification of the hospital officer or employee responsible for its
17 implementation;

18 ~~(9)~~ ~~Information concerning recently completed or ongoing quality~~
19 ~~improvement and patient safety projects.~~

1 ~~(10) A description of strategic initiatives discussed with or derived from~~
2 ~~the identification of health care needs; the one-year and four-year capital~~
3 ~~expenditure plans; and the depreciation schedule for existing facilities.~~

4 ~~(11)(3) Information~~ information on membership and governing body
5 qualifications, a listing of the current governing body members, and means of
6 obtaining a schedule of meetings of the hospital's governing body, including
7 times scheduled for public participation; and

8 (4) a link to the comparative statewide hospital quality report.

9 ~~(12) Valid, reliable, and useful information on nurse staffing, including~~
10 ~~comparisons to appropriate industry benchmarks for safety. This information~~
11 ~~may include system-centered performance measures, such as skill mix, nursing~~
12 ~~care hours per patient day, and other such system-centered performance~~
13 ~~measures as reliable industry benchmarks become available in the future.~~

14 ~~(b) On or before January 1, 2005, and annually thereafter beginning on~~
15 ~~June 1, 2006, the board of directors or other governing body of each hospital~~
16 ~~licensed under chapter 43 of this title shall publish on its website, making~~
17 ~~paper copies available upon request, its community report in a uniform format~~
18 ~~approved by the Commissioner of Health and in accordance with the standards~~
19 ~~and procedures adopted by rule under this section. Hospitals located outside~~
20 ~~this State which serve a significant number of Vermont residents, as~~

1 ~~determined by the Commissioner of Health, shall be invited to participate in~~
2 ~~the community report process established by this subsection.~~

3 (c) ~~The community reports shall be provided to the Commissioner of~~
4 ~~Health.~~ The Commissioner of Health shall publish the reports statewide
5 comparative hospital quality report on a public website and shall ~~develop and~~
6 ~~include a format for comparisons of hospitals within the same categories of~~
7 quality and financial measures update the report at least annually beginning on
8 June 1, 2017.

9 Sec. 3. 18 V.S.A. § 9408a is amended to read:

10 § 9408a. UNIFORM PROVIDER CREDENTIALING

11 * * *

12 (e) ~~The commissioner may enforce compliance with the provisions of this~~
13 ~~section as to insurers and as to hospitals as if the hospital were an insurer under~~
14 ~~8 V.S.A. § 3661. [Repealed.]~~

15 * * *

16 Sec. 4. 18 V.S.A. § 9414 is amended to read:

17 § 9414. QUALITY ASSURANCE FOR MANAGED CARE

18 (a) The Commissioner shall have the power and responsibility to ensure
19 that each managed care organization provides quality health care to its
20 members, in accordance with the provisions of this section.

1 (2) A managed care organization shall participate in ~~establish a chronic~~
2 ~~care program as needed to implement~~ the Blueprint for Health established in
3 chapter 13 of this title. ~~The program~~ If needed to implement the Blueprint, a
4 managed care organization shall establish a chronic care program, which shall
5 include:

6 (A) appropriate benefit plan design;

7 (B) informational materials, training, and follow-up necessary to
8 support members and providers; and

9 (C) payment reform methodologies.

10 (3) Each managed care organization shall have procedures to assure
11 availability, accessibility, and continuity of care, and ongoing procedures for
12 the identification, evaluation, resolution, and follow-up of potential and actual
13 problems in its health care administration and delivery.

14 (4) Each managed care organization shall be accredited by a national
15 independent accreditation organization approved by the Commissioner.

16 (c) ~~The~~ Consistent with participation in the Blueprint for Health pursuant to
17 subdivision (b)(2) of this section and the accreditation required by subdivision
18 (b)(4) of this section, the managed care organization shall have an internal
19 quality assurance program to monitor and evaluate its health care services,
20 including primary and specialist physician services, and ancillary and
21 preventive health care services, across all institutional and noninstitutional

1 settings. The internal quality assurance program shall be fully described in
2 written form, provided to all managers, providers, and staff and made available
3 to members of the organization. The components of the internal quality
4 assurance program shall include, ~~but not be limited to,~~ the following:

5 (1) a peer review committee or comparable designated committee
6 responsible for quality assurance activities;

7 (2) accountability of the committee to the Board of Directors or other
8 governing authority of the organization;

9 (3) participation by an appropriate base of providers and support staff;

10 (4) supervision by the medical director of the organization;

11 (5) regularly scheduled meetings; and

12 (6) minutes or records of the meetings which describe in detail the
13 actions of the committee, including problems discussed, charts reviewed,
14 recommendations made, and any other pertinent information.

15 ~~(d)(1) In addition to its internal quality assurance program, each managed~~
16 ~~care organization shall evaluate the quality of health and medical care provided~~
17 ~~to members. The organization shall use and maintain a patient record system~~
18 ~~which will facilitate documentation and retrieval of statistically meaningful~~
19 ~~clinical information.~~

1 ~~(2) A managed care organization may evaluate the quality of health and~~
2 ~~medical care provided to members through an independent accreditation~~
3 ~~organization.~~ [Repealed.]

* * *

5 Sec. 5. 18 V.S.A. § 9414a is amended to read:

6 § 9414a. ANNUAL REPORTING BY HEALTH INSURERS

7 (a) As used in this section:

8 (1) “Adverse benefit determination” means a denial, reduction,
9 modification, or termination of, or a failure to provide or make payment in
10 whole or in part for, a benefit, including:

11 (A) a denial, reduction, modification, termination, or failure to
12 provide or make payment that is based on a determination of the member’s
13 eligibility to participate in a health benefit plan;

14 (B) a denial, reduction, modification, or termination of, or failure to
15 make payment in whole or in part for, a benefit resulting from the application
16 of any utilization review; and

17 (C) a failure to provide coverage for an item or service for which
18 benefits are otherwise provided because the item or service is determined to be
19 experimental, investigational, or not medically necessary or appropriate.

1 (2) “Claim” means a request for payment for a covered service that a
2 member or the member’s health care provider submits to the insurer at or after
3 the time that health care services have been provided.

4 (3) “Concurrent review” means utilization review conducted during a
5 member’s stay in a hospital or other facility, or during another ongoing course
6 of treatment.

7 (4) “Grievance” means a complaint submitted by or on behalf of a
8 member regarding:

9 (A) an adverse benefit determination;

10 (B) the availability, delivery, or quality of health care services;

11 (C) claims payment, handling, or reimbursement for health care
12 services; or

13 (D) matters relating to the contractual relationship between a member
14 and the managed care organization or health insurer offering the health benefit
15 plan.

16 (5) “Independent external review” means a review of a health care
17 decision by an independent review organization pursuant to 8 V.S.A. § 4089f.

18 (6) “Post-service review” means the review of any claim for a benefit
19 that is not a pre-service or concurrent review.

1 (7) “Pre-service review” means the review of any claim for a benefit
2 with respect to which the terms of coverage condition receipt of the benefit in
3 whole or in part on approval of the benefit in advance of obtaining health care.

4 (8) “Utilization review” means a set of formal techniques designed to
5 monitor the use, or evaluate the clinical necessity, appropriateness, efficacy, or
6 efficiency, of health care services, procedures, or settings, including
7 prescription drugs.

8 (b) Health insurers with a minimum of 2,000 Vermont lives covered at the
9 end of the preceding year or who offer insurance through the Vermont Health
10 Benefit Exchange pursuant to 33 V.S.A. chapter 18, subchapter 1 shall
11 annually report the following information to the Commissioner of Financial
12 Regulation, in plain language, as an addendum to the health insurer’s annual
13 statement:

14 (1) the health insurer’s state of domicile and the total number of states in
15 which the insurer operates;

16 (2) the total number of Vermont lives covered by the health insurer;

17 (3) the total number of claims submitted to the health insurer;

18 (4) the total number of claims denied by the health insurer, including the
19 total number of denied claims for mental health services, treatment for
20 substance use disorder, and prescription drugs;

1 (5) data regarding the number and percentage of denials of service by
2 the health insurer ~~at the preauthorization level, based on utilization review,~~
3 including utilization review at the pre-service review, concurrent review, and
4 post-service review levels and including denials of mental health services,
5 services for substance use disorder, and prescription drugs broken out
6 separately, including:

7 (A) ~~the total number of~~ denials of service by the health insurer ~~at the~~
8 ~~preauthorization level;~~

9 (B) ~~the total number of~~ denials of service ~~at the preauthorization level~~
10 appealed to the health insurer at the first-level grievance and, of those, the total
11 number overturned;

12 (C) ~~the total number of~~ denials of service ~~at the preauthorization level~~
13 appealed to the health insurer at any second-level grievance and, of those, the
14 total number overturned;

15 (D) ~~the total number of~~ denials of service at the ~~preauthorization~~
16 pre-service level for which external review was sought and, of those, the total
17 number overturned;

18 (6) the total number of adverse benefit determinations made by the
19 health insurer, including:

1 (A) the total number of adverse benefit determinations appealed to
2 the health insurer at the first-level grievance and, of those, the total number
3 overturned;

4 (B) the total number of adverse benefit determinations appealed to
5 the health insurer at any second-level grievance and, of those, the total number
6 overturned;

7 (C) the total number of adverse benefit determinations for which
8 external review was sought and, of those, the total number overturned;

9 ~~(7) the total number of claims denied by the health insurer because the~~
10 ~~service was experimental, investigational, or an off-label use of a drug, was not~~
11 ~~medically necessary, involved access to a provider that is inconsistent with the~~
12 ~~limitations imposed by the plan, or was subject to a preexisting condition~~
13 ~~exclusion; [Repealed.]~~

14 (8) the total number of claims denied by the health insurer as duplicate
15 claims, as coding errors, or for services or providers not covered;

16 (9) the percentage of claims processed in a timely manner;

17 (10) the percentage of claims processed correctly;

18 (11) the composite percentage of claims processed in a timely manner
19 and correctly;

20 (12) the number and percentage of utilization review decisions meeting
21 the timelines described in subdivisions (A)–(D) of this subdivision (12),

1 including timeliness data for all utilization review decisions and timeliness
2 data for physical health, mental health, substance use disorder, and prescription
3 drug utilization review decisions broken out separately:

4 (A) concurrent reviews within 24 hours;

5 (B) urgent pre-service reviews within 48 hours of receipt of the
6 request;

7 (C) non-urgent pre-service reviews within two business days of
8 receipt of request; and

9 (D) post-service reviews within 30 days of receipt of request;

10 (13) data regarding the number of grievances related to availability,
11 delivery, or quality of health care services or matters relating to the contractual
12 relationship between a member and the health insurer, including:

13 (A) health care provider performance and office management issues;

14 (B) plan administration;

15 (C) access to health care providers and services;

16 (D) access to mental health providers and services; and

17 (E) access to substance use disorder providers and services;

18 (14) the total number of claims, including separate numbers for claims
19 related to mental health services, services for substance use disorder, and
20 prescription drugs, denied by the health insurer on the grounds that the service
21 was experimental, investigations, or an off-label use of a drug; was not

1 medically necessary; or involved access to a provider that is inconsistent with
2 the limitations imposed by the plan;

3 (15) results of surveys evaluating health care provider satisfaction with
4 the health insurer;

5 (16) the health insurer's actions taken in response to the prior year's
6 health care provider survey results;

7 (17)(A) the titles and salaries of all corporate officers and board
8 members during the preceding year;

9 (B) the bonuses and compensatory benefits of all corporate officers
10 and board members during the preceding year;

11 ~~(10)~~(18) the health insurer's marketing and advertising expenses during
12 the preceding year;

13 ~~(11)~~(19) the health insurer's federal and Vermont-specific lobbying
14 expenses during the preceding year;

15 ~~(12)~~(20) the amount and recipient of each political contribution made by
16 the health insurer during the preceding year;

17 ~~(13)~~(21) the amount and recipient of dues paid during the preceding year
18 by the health insurer to trade groups that engage in lobbying efforts or that
19 make political contributions;

20 ~~(14)~~(22) the health insurer's legal expenses related to claims or service
21 denials during the preceding year; and

1 ~~(15)~~(23) the amount and recipient of charitable contributions made by
2 the health insurer during the preceding year.

3 ~~(b)~~(c) Health insurers may indicate the extent of overlap or duplication in
4 reporting the information described in subsection ~~(a)~~(b) of this section.

5 ~~(e)~~(d) The Department of Financial Regulation shall create a standardized
6 form using terms with uniform, industry-standard meanings for the purpose of
7 collecting the information described in subsection ~~(a)~~(b) of this section, and
8 each health insurer shall use the standardized form for reporting the required
9 information as an addendum to its annual statement. To the extent possible,
10 health insurers shall report information specific to Vermont on the
11 standardized form and shall indicate on the form where the reported
12 information is not specific to Vermont.

13 ~~(d)~~(e)(1) The Department of Financial Regulation and the Office of the
14 Health Care Advocate shall post on ~~its website~~ their websites links to the
15 standardized form completed by each health insurer pursuant to this section.
16 Each health insurer shall post its form on its own website.

17 (2) The Department of Vermont Health Access shall post on the
18 Vermont Health Benefit Exchange established pursuant to 33 V.S.A.
19 chapter 18, subchapter 1 an electronic link to the standardized forms posted by
20 the Department of Financial Regulation pursuant to subdivision (1) of this
21 subsection.

1 ~~(e)~~(f) The Commissioner of Financial Regulation may adopt rules pursuant
2 to 3 V.S.A. chapter 25 to carry out the purposes of this section.

3 Sec. 6. 18 V.S.A. § 1854(a) is amended to read:

4 (a) A hospital shall make public the maximum patient census and the
5 number of registered nurses, licensed practical nurses, and licensed nursing
6 assistants providing direct patient care in each unit during each shift. Each
7 unit's information shall be reported in full-time equivalents, with either every
8 eight hours or 12 hours worked by a registered nurse, licensed practical nurse,
9 or licensed nursing assistant during the shift as one full-time equivalent. The
10 reporting of this information shall be in a manner consistent with the
11 requirements for public reporting for measures of nurse staffing selected by the
12 ~~commissioner of financial regulation~~ Commissioner of Health under
13 subdivision ~~9405b(a)(12)~~ 9405b(a)(4) of this title, but shall not in any way
14 change what is required to be posted as set forth in this subsection. Each unit's
15 information shall be posted in a prominent place that is readily accessible to
16 patients and visitors in that unit at least once each day. The posting shall
17 include the information for the preceding seven days.

18 Sec. 7. EFFECTIVE DATES

19 (a) Secs. 1 (hospital needs assessment) and 2 (hospital community reports)
20 and this section shall take effect on passage.

21 (b) The remaining sections shall take effect on July 1, 2016.