A-159

BILL AS INTRODUCED
1997

ORIGINAL

H.163

Introduced by Representative Kehler of Pomfret

Referred to Committee on Health & Welfare

Date:

Subject: Insurance; health insurance; public counsel for health insurance

Statement of purpose: This bill proposes to authorize the public counsel for health insurance to represent the interests of health insurance consumers in Vermont.

AN ACT RELATING TO THE PUBLIC COUNSEL FOR HEALTH INSURANCE

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

See P. 1a

~~Sec. 1. 8 V.S.A. § 7 is added to read:~~

§ 7. PUBLIC COUNSEL FOR HEALTH INSURANCE

(a) The governor, with the advice and consent of the senate, shall appoint a public counsel for health insurance to represent the interests of health insurance consumers in Vermont for a term of two years, ending on February 1 of each odd-numbered year. The public counsel shall be a resident of Vermont, licensed to practice law in Vermont, and shall have the knowledge and experience necessary to practice effectively in health insurance proceedings. The public counsel, and the public counsel's spouse, shall not be a ~~health care provider, or be employed by or affiliated with a health care provider, health~~

H. 163 See Pg. 1c

~~Sec. 1. 8 V.S.A. § 7 is added to read:~~

§ 7. VERMONT ADVOCATE FOR HEALTH CARE CONSUMERS

The department shall contract for the services of an advocate for health care consumers to represent the interests of Vermont consumers of health insurance. See P. 1b *Annually, on or before January 15, the advocate for health care consumers shall report to the governor and the general assembly on the advocate's activities and fiscal accounts during the preceding year and recommendations for improving consumer protection regarding health care and health care insurance. The advocate may also:*

(1) Inquire into the policies, practices and activities of managed care organizations and health insurers to determine whether those policies, practices and activities are in the best interests of the residents of Vermont. Any managed care organization or health insurer shall disclose to the advocate all information necessary to carry out the duties of the advocate to the extent the information is not deemed confidential by law.

(2) Intervene in, as a matter of right, any administrative proceeding under this title or chapter 221 of Title 18 relating to health insurance and managed care organizations to represent the interests of health insurance consumers;

(3) Commence or intervene in any judicial proceeding to represent the interests of the public relating to managed care or health insurance.

by containing costs in Vermont's health care system through the promotion of affordable health insurance and quality health care for all Vermonters

H. 163

Sec. 1. 8 V.S.A. § 4089d is added to read:

§ 4089d. INDEPENDENT EXTERNAL REVIEW OF HEALTH CARE SERVICE DECISIONS

(a) For the purposes of this section,

(1) "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health insurer, as defined in 18 V.S.A. § 9402(7), to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(2) "Insured" means the beneficiary of a health benefit plan, including the subscriber and all others covered under the plan.

(b) An insured who has exhausted all applicable internal review procedures provided by the health benefit plan shall have the right to an independent external review of a decision under a health benefit plan to deny, reduce or terminate health care coverage or to deny payment for a health care service. The independent review shall be available when requested in writing by the affected insured, provided the decision to be reviewed requires the plan to expend at least $100.00 for the service and the decision by the plan is based on one of the following reasons:

(1) The health care service is a covered benefit that the health insurer has determined to be not medically necessary.

(2) A limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and regulations.

(3) The health care treatment has been determined to be experimental, investigational or an off-label drug.

(4) The health care service involves a medically-based decision that a condition is preexisting.

(c) The right to review under this section shall not be construed to change the

terms of coverage under a health benefit plan.

(d) The department shall adopt rules necessary to carry out the purposes of this section. The rules shall ensure that the independent external reviews have the following characteristics:

(1) The independent external reviews shall be conducted.

(A) By independent review organizations pursuant to a contract with the department, and the reviewers shall include health care providers credentialed with respect to the health care service under review and have no conflict of interest relating to the performance of their duties under this section.

(B) In accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services.

(2) An insured shall:

(A) Be provided with adequate notice of the review rights under this section.

(B) Have the right to use outside assistance during the review process and to submit evidence relating to the health care service.

(C) Pay a filing fee in an amount that reflects the administrative costs of processing a request for review under this section, which shall not be more than $25.00. The filing fee may be waived or reduced based on a determination by the commissioner that the financial circumstances of the insured warrant a waiver or reduction.

(D) Be protected from retaliation for exercising their right to an independent external review under this section.

(3) Other costs of the independent review shall be paid by the health benefit plan.

(4) The independent review organization shall issue to both parties a written

review decision that is evidence-based. The decision shall be binding on the health benefit plan.

(5) The confidentiality of any health care information acquired or provided to the independent review organization shall be maintained in compliance with any applicable state or federal laws.

(6) The records of, and internal materials prepared for specific reviews by any independent review organization under this section shall be exempt from public disclosure under 1 V.S.A. § 316.

(e) Decisions relating to health care services for mental health and substance abuse conditions shall not be reviewed under this section, but shall be reviewed by the procedure provided in section 4089a of this title.

(f) Decisions relating to the following health care services shall not be reviewed under this section, but shall be reviewed by the review process provided by law:

(1) Health care services provided by the Vermont Medicaid program or Medicaid benefits provided through a contracted health plan.

(2) Health care services provided to inmates by the department of corrections.

Sec. 2. 8 V.S.A. chapter 107, subchapter 1A is added to read:

Subchapter 1A. Health Care Ombudsman

§ 4089e. DEFINITIONS

As used in this subchapter,

(1) "Health insurance" means any group or individual health care benefit policy, contract or plan offered, issued, or renewed to a Vermont resident, including any health care benefit plan offered, issued, or renewed by any health insurance company, any nonprofit hospital and medical service corporation, any managed care organization as defined by section 9402(10) of Title 18, or by any self-insured organization, or by this state or any subdivision or instrumentality of the state, except the commissioner may exempt any plan if the exemption is required by federal

law.

(2) "Health insurer" means any person who offers, issues, or renews a health insurance policy, contract, or plan, except that the commissioner may exempt any person if the exemption is required by federal law.

§ 4089f. OFFICE OF HEALTH CARE OMBUDSMAN

(a) The department shall establish the office of the health care ombudsman by contract with any nonprofit organization. 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:

(1) Assist health insurance consumers with health insurance plan selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and services.

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

(3) Provide information to the public, agencies, legislators and others regarding

problems and concerns of health insurance consumers and shall make recommendations for resolving those problems and concerns.

(4) Identify, investigate and resolve complaints on behalf of individual health insurance consumers and assist those consumers with the filing and pursuit of complaints and appeals.

(5) Analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to health insurance consumers, and recommend changes it deems necessary.

(6) Facilitate public comment on laws, regulations, and policies, including policies and actions of health insurers.

(7) Promote the development of citizen and consumer organizations.

(8) Ensure that health insurance consumers have timely access to the services provided by the office.

(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.

(c) The state health care ombudsman may:

(1) Hire or contract with persons to fulfill the purposes of this subchapter.

(2) Review the health insurance records of a consumer who has provided written consent. Based on the written consent of the consumer or the consumer's guardian or legal representative, a health insurer shall provide the state ombudsman access to records relating to that consumer.

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

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

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

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

(d) All state agencies shall comply with reasonable requests from the state ombudsman for information and assistance. The department may adopt rules necessary to assure the cooperation of state agencies under this subsection.

(e) In the absence of written consent by a complainant or an individual utilizing the services of the office, or his or her guardian or legal representative, or court order, the state ombudsman, its employees and contractors, shall not disclose the identity of the complainant or individual.

(f) The state ombudsman, its employees and contractors shall not have any conflict of interest relating to the performance of their responsibilities under this subchapter. For the purposes of this section, a conflict of interest exists whenever

the state ombudsman, its employees, contractors or a person affiliated with the state ombudsman, its employees and contractors:

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

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

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

(4) receive or have the right to receive, directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer or health care provider.

(g) The state ombudsman shall be able to speak on behalf of the interests of health care and health insurance consumers and to carry out all duties prescribed in this subchapter without being subject to any disciplinary or retaliatory action. Nothing in this subsection shall limit the authority of the commissioner to enforce the terms of the contract.

Sec. 2a. HEALTH CARE OMBUDSMAN IMPLEMENTATION REPORT

The commissioner of banking, insurance, securities and health care administration and the health care ombudsman shall report to the joint fiscal committee and the health access oversight committee on or before September 15, 1998, and periodically thereafter during 1998 at the request of either committee. The report shall provide the committees with an update on the status of implementation of the health care ombudsman program, together with a description of the manner in which the health care ombudsman is, and will in the future be coordinating his or her activities with existing ombudsman programs such as the Vermont health access plan ombudsman, and the Vermont long term care ombudsman.

Sec. 3. 8 V.S.A. § 3681(5) is amended to read:

As used in this subchapter:

(5) "Insurer" means a company qualified and licensed to transact the business of insurance in this state and shall include a health maintenance organization, except that it shall not include

* * *

Sec. 4. 8 V.S.A. § 5102b is amended to read:

§ 5102b. SOLVENCY PROTECTIONS

* * *

(e) If the commissioner determines that the premiums received by a health maintenance organization for its Vermont members exceed $2,000,000.00 for any calendar year and or that the health maintenance organization was incorporated in a state without solvency protections that are substantially equivalent to those offered under this chapter, the commissioner may order that Vermont contracts be conducted through an affiliate or subsidiary corporation incorporated under Vermont law.

* * *

(l) The commissioner shall adopt rules that establish solvency standards for provider- sponsored networks, including provider-sponsored organizations, for the Medicare + Choice program, as described in 42 U.S.C. § 1395w-21, in conformance with the solvency standards established by the Secretary of Health and Human Services under 42 U.S.C. § 1395w-26. Provider-sponsored networks shall be licensed under this chapter to offer a Medicare+Choice plan by complying with the solvency rules adopted under this subsection; except that a provider-sponsored network that offers any health plan other than or in addition to a Medicare + Choice plan shall comply with the solvency standards of this chapter instead of those adopted specifically for Medicare + Choice plans under this subsection. A provider-sponsored network licensed under this chapter shall not be required to offer any insurance product apart from Medicare+Choice. For purposes of this subsection, "provider-sponsored network" or "provider-sponsored organization" shall have the

same definition as in 42 U.S.C. § 1395w-25(d).

(m) The commissioner may enter into contracts with the Secretary of Health and IIuman Services for the administration of Medicare+Choice program.

Sec. 5. 8 V.S.A. § 5107a is added to read:

§ 5107a. APPLICATION FOR CONTINUING AUTHORITY UPON MERGER, CONSOLIDATION, TRANSFER OF CONTROL OR SALE OF CONTRACTS

(a) If a health maintenance organization that annually writes more than $10 million of premium in this state intends to merge into or with or consolidate with, transfer more than 10 percent of its stock or other ownership interest, to sell or dispose of all or substantially all of its assets to, or transfer more than 25 percent of its Vermont contracts to any other person, that person may succeed on a continuing basis to the authority possessed by the health maintenance organization if:

(1) A plan of merger, consolidation or operation and an application for continuing authority is approved by the commissioner. The application for continuing authority must comply with subsections (b) and(c) of section 5102 of this title. The applicant shall provide such additional information as the commissioner may require;

(2) The proposed surviving or acquiring person, if a health maintenance organization within the meaning of subdivision (2) of section 5101 of this title, is qualified to obtain a certificate of authority under the provisions of this chapter;

(3) The proposed surviving or acquiring person is in compliance with all of the requirements of this chapter and, if licensed or authorized under any other provision of this title, is in compliance with all applicable laws of this state;

(4) The commissioner finds that the transaction will promote the general good of the members of the health maintenance organization and the public, taking into account the effect the transaction will have on competition in this state and that the applicant is in compliance with this section; and

(5) The health maintenance organization has obtained all required regulatory approvals from any other state with jurisdiction over the transaction or the commissioner's approval is effective upon the issuance of such approvals.

(b) For purposes of this section, a "health maintenance organization" includes a "health maintenance organization", as defined in subdivision 5101(2) of this title, that is authorized to transact business in this state, and any person who, directly or indirectly, has the power to direct or control the policies or management of a health maintenance organization that is authorized to transact business in this state, whether through an ownership interest or otherwise and the health maintenance organization is affected by a transaction described in subsection (a) of this section. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting interests of a health maintenance organization or has the power, directly and indirectly, to appoint one or more directors of the health maintenance organization.

(c) In approving the plan or application or in making findings under this section, the commissioner may consider and rely on the record of any previous proceeding or order of the commissioner of the state of domicile of a health maintenance organization with respect to the transaction.

(d) The commissioner may exempt from the provisions of this section any transaction that does not have a material impact on Vermont members.

Sec. 6. 18 V.S.A. § 9431 is amended to read:

§ 9431. POLICY AND PURPOSE

It is declared to be the public policy of this state that the general welfare and protection of the lives, health and property of the people of this state require that all new institutional health services be offered or developed in a manner which avoids unnecessary duplication, contains or reduces increases in the cost of delivering services, while at the same time maintain and improve the quality of and access to

health care services, and promotes rational allocation of health care resources in the state; and that the need, cost, type, level, quality, and feasibility of providing any new institutional health services be subject to review and assessment prior to any offering or development. In order to carry out the policy goals of this subchapter, the department shall develop certificate of need guidelines to assist in its decision-making. The certificate of need guidelines shall be consistent with the state health plan.

Sec. 7. 18 V.S.A. § 9432(14) is added to read:

(14) "Cardiac catheterization laboratory" means a facility, or portion of a facility, in which cardiac catheterization procedures, whether diagnostic or therapeutic, are conducted.

Sec. 8. 18 V.S.A. §9434(a)(7) is added to read:

(7) the offering of any cardiac catheterization laboratory service.

Sec. 9. 18 V.S.A. § 9436(a)(2) is amended to read:

(2) The relationship of the proposed new institutional health service to the ~~health resource management plan~~ state health plan, ~~whichever applies~~; and the unified health care budget.

Sec. 10. 18 V.S.A. § 9437(5) is amended to read:

(5) The proposed new institutional health service is consistent with the ~~health resource management plan or~~ certificate of need guidelines published by the department in accordance with its rules, and is within the portion of the unified health care budget applicable to the proposed health care facility.

Sec. 11. 18 V.S.A. § 9440(b)(6) is amended to read:

(6) For purposes of this section, "interested party" status shall be granted to persons who demonstrate that they will be substantially, adversely and directly affected by the new institutional health service under review or that they will materially assist the commissioner by providing nonduplicative evidence relevant to the determination. Once interested party status is granted the commissioner shall

provide the information necessary to enable the party to participate in the formal ~~hearing~~ review process. Such information includes information about procedures, copies of all written correspondence and copies of all entries in the application record.

Sec. 12. 1 V.S.A. § 317(b)(28) is added to read:

(28) records of, and internal materials prepared for independent external reviews of health care service decisions pursuant to 8 V.S.A. § 4089d.

Sec. 13. TRANSFER OF POSITIONS; POSITIONS AUTHORIZED

In fiscal year 1999 the following positions shall be transferred and converted from areas of government to be determined by the secretary of administration to fill two positions authorized in the department of banking, insurance, securities, and health care administration as follows:

(1) One (1) administrative assistant B.

(2) One (1) level IV staff attorney.

Sec. 14. APPROPRIATION

During fiscal year 1998 the sum of $300,000.00 shall remain in the insurance regulatory and supervision fund and shall carry forward in the fund for expenditures in fiscal year 1999. The $300,000.00 is appropriated from the insurance regulatory and supervision fund to the commissioner of banking, insurance, securities, and health care administration in fiscal year 1999 to carry out the purposes of this act.

Sec.14a. 18 V.S.A. § 9418 is added to read:

§ 9418. PAYMENT FOR HEALTH CARE SERVICES

(a) As used in this section,

(1) "Health plan" means a health insurer, disability insurer, health maintenance organization, medical or hospital service corporation or a workers' compensation policy of a casualty insurer licensed to do business in Vermont. "Health plan" also includes a health plan that requires its medical groups, independent practice associations or other independent contractors to pay claims for

the provision of health care services.

(2) "Claim" means any claim, bill or request for payment for all or any portion of provided health care services that is submitted by:

(A) A health care provider or a health care facility pursuant to a contract or agreement with the health plan; or

(B) A health care provider, a health care facility or a patient covered by the health plan.

(3) "Contest" means the circumstance in which the health plan was not provided with:

(A) Sufficient information needed to determine payer liability; or

(B) Reasonable access to information needed to determine the liability or basis for payment of the claim.

(4) "Denied" or "denial" means the circumstance in which the plan asserts that it has no liability to pay a claim, based on eligibility status of the patient, coverage of a service under the health plan, medical necessity of a service, liability of another payer or other grounds.

(b) No later than 45 days following receipt of a claim, a health plan shall do one of the following:

(1) Pay or reimburse the claim.

(2) Notify the claimant in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.

(c) If the claim submitted is to a health plan that is a workers' compensation insurance policy,

(1) The health plan shall within 45 days following receipt of the claim:

(A) pay or reimburse the claim; or

(B) notify in writing the claimant and the commissioner of labor and

industry that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.

(2) Disputes regarding any claims under this subsection shall be resolved pursuant to the provisions of chapters 9 and 11 of Title 21.

(3) The commissioner of labor and industry may assess interest and penalties as provided in subsections (e) and (f) of this section against a health plan that fails to comply with the provisions of this section or any order of the commissioner. These remedies are in addition to any other penalties available under Title 8 and chapters 9 and 11 of Title 21.

(d) If a claim is contested because the health plan was not provided with sufficient information to determine payer liability and for which written notice has been provided as required by subdivision (b)(2) of this section, then the health plan shall have 45 days after receipt of the additional information to complete consideration of the claim.

(e) Interest shall accrue on a claim at the rate of 12 percent per annum calculated as follows:

(1) For a claim that is uncontested, from the first calendar day following the 45-day period following the date the claim is received by the health plan.

(2) For a contested claim, for which notice was provided as required by this section, from the first calendar day after the 45-day period following the date that sufficient additional information is received.

(3) For a contested claim for which notice was not provided as required by this section or for which notice was provided later than the 45 days required by subdivision (b)(2) of this section, from the first calendar day after the 45-day period following the date the original claim was received by the health plan.

(4) For a claim that was denied, from the first calendar day after the 45-day period following the date of a final arbitration award, judgment or administrative

order that found a plan to be liable for payment of the claim.

(f) The commissioner may suspend the accrual of interest under subsection (e) if the commissioner determines that the health plan's failure to pay a claim within the applicable time limit is the result of a major disaster, act-of-God or unanticipated major computer system failure or that the action is necessary to protect the solvency of the health plan.

(g) All payments shall be made within the time periods provided by this section unless otherwise specified in the contract between the health plan and the health care provider or the health care facility. The health plan shall provide notice as required by subsection (b) of this section and pay interest on uncontested and contested claims as required in subsection (d) of this section from the day following the contract payment period, unless otherwise specified in the contract.

(h) Any dispute concerning payment of a claim or interest on a claim, arising out of or relating to the provisions of this section shall, at the option of either party, be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, and judgment upon the arbitrator's award may be entered in any court having jurisdiction.

(i) If the commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the commissioner may impose an administrative penalty against the health plan of no more than $500.00 for each violation. In determining the amount of penalty to be assessed, the commissioner shall consider the following factors:

(1) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan.

(2) The gravity of the violation or practice.

(3) The history of previous violations or practices of a similar nature.

(4) The economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation.

(5) Any other relevant factors.

Sec. 14b. EXTENSION OF SUNSET; REPEAL

Sec. 14a of Act No. 54 (1997) is repealed. Notwithstanding any other provision of law, 8 V.S.A. § 5107(g) (health maintenance organization formed as limited liability company) is repealed on July 1, 1999.

Sec. 15. EFFECTIVE DATES

This act shall take effect on July 1, 1998, except that:

(1) This section and Secs. 1, 3, 6, 7, 8, 11, and 12 shall be effective on passage. Secs. 4 and 5 shall also be effective on passage and shall apply to all transactions that are effective on or after passage.

(2) Secs. 9 and 10 shall take effect on March 15, 1999.

(3) Rules for the independent external review of health care service decisions in Sec. 1 shall be adopted no later July 1, 1999, and the independent external review procedure shall be fully implemented no later than October 1, 1999.

Michael J. Obuchowski
SPEAKER OF THE HOUSE OF REPRESENTATIVES

ATTESTED TO:

Donald G. Milne
Clerk, House of Representatives

Donald A. Tucker
PRESIDENT OF THE SENATE

4/29/98
GOVERNOR Date

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

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

§ 8. VERMONT HEALTH CARE SUPERVISORY FUND; ESTABLISHED

(a) The Vermont health care supervisory fund is hereby established in the state treasury for the purpose of supporting the activities for consumer protection by the division of health care administration including administrative and operational expenses, employee salary and benefits and contractual services and associated expenses. The fund shall consist of assessments collected pursuant to subsection (b) of this section. Interest earned on the fund and any monies remaining in the fund at the end of any fiscal year shall be carried forward and retained in 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) The health care supervisory fund created in subsection (a) of this section shall be funded by an assessment of $1.25 for each life covered by a health insurance company, medical service corporation, hospital service corporation, health maintenance organization or other health benefit plan, managed care plan, supplemental Medicare policy or any policy as defined in 8 V.S.A. § 4079. There shall be no assessment under this section for lives

insured under the following types of insurance policies: disability, long-term care, limited-benefit policies, credit , stop-loss or excess loss and policies providing coverage exclusively for dental care. The assessment shall be based on the total number of covered lives as of December 31 of the preceding year. Covered lives shall include Vermont residents in the case of individual coverage and all lives covered by a group policy for which the purchaser is located in Vermont. 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. In addition to any other sanctions available to the commissioner for violations of Titles 8 and 18, the commissioner may collect any assessments not paid by October 1 by civil action. In a civil collection action, the commissioner may assess costs of collection, reasonable attorney fees and interest at the rate of 12 percent per annum from the date of delinquency.

Sec. 3. REPORT

The commissioner of banking, insurance, securities, and health care administration shall report to the general assembly:

(1) No later than January 1, 1998, on the progress of the initial phase of implementation of this act to be included in the report required in Sec. 40 of No.180 of the Acts of 1996.

(2) No later than January 1, 1999, on the progress of the implementation of this act, including the amount of monies in the health care supervisory fund, the establishment and accomplishments of the positions and the activities of the division of health care administration in carrying out the

~~purposes of this act.~~

Sec. 4. TRANSFER OF POSITIONS; POSITIONS AUTHORIZED

In fiscal 1998, 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 (1) information and education specialist or representative

(2) One (1) staff investigator.

(2) One (1) level III staff attorney.

Sec. 5. APPROPRIATION

There is appropriated to the health care supervisory fund for fiscal year 1998, the amount of $400,000.00 to carry out the provisions of this act including $150,000.00 for the contract for the advocate for health care consumers pursuant to 8 V.S.A. § 7.

Sec. 6. SUNSET

8 V.S.A. §7 (Vermont advocate for health care consumers) is repealed on July 1, 1999.

care facility, health insurer, or the department of banking, insurance, securities, and health care administration.

(b)(1) The public counsel for health insurance shall:

(A) survey and make inquiry into the policies, practices, and activities of health insurers and the department of banking, insurance, securities, and health care administration, and determine whether such policies, practices, and activities are in the best interests of the people of this state. The department and any health insurer shall disclose to the public counsel any information necessary or desirable in carrying out the powers and duties of the public counsel, unless such information is made confidential by law. A health insurer's trade secret information may be disclosed to the public counsel under seal, and thereafter shall not be further disclosed; and

(B) file an annual report on or before January 1 with the governor and the general assembly on the counsel's performance and fiscal accounts during the preceding fiscal year;

(2) The public counsel may:

(A) commence, or intervene as a matter of right as a party or otherwise, in any administrative proceeding authorized by this title, or chapter 221 of Title 18 relating to health insurance and managed care organizations, including proceedings relating to health insurance rates, forms, and rules, in order to represent the interests of health insurance consumers;

(B) commence, or intervene in any judicial proceeding to represent the interests

~~of the public relating to health insurance;~~

(C) recommend to the general assembly, the governor, and agencies and instrumentalities of the state such actions as may enhance the interests of health insurance consumers in Vermont;

(D) employ or contract with such professional, technical, and other personnel needed to carry out the provisions of this section; and

(E) do all things necessary or desirable, not inconsistent with the law, in order to carry out the purposes of this section.

(c) The public counsel for health insurance special fund is created pursuant to subchapter 5 of chapter 7 of Title 32, to support the expenses of the public counsel for health insurance. Into the fund shall be deposited an assessment, in the amount of $2.00, imposed and collected annually on each individual health insurance policy, hospital or medical service corporation service contract, and health maintenance organization health benefit plan, and on each individual certificate of a group policy, service contract and benefit plan issued or renewed in this state during each calendar year. The assessment imposed by this subsection shall be collected in the manner provided for the insurance premium tax imposed by subchapter 7 of chapter 211 of Title 32. Disbursements from the fund shall be made on warrants drawn by the commissioner of finance and management in anticipation of receipts authorized by this subsection.

(d) As used in this section:

~~(1) "Health insurer" means any health insurance company, any nonprofit hospital or~~

medical service corporation service contract, any health maintenance organization, and any managed care organization, as defined by 18 V.S.A. § 9402(10).

(2) "Health insurance" shall include any health insurance policy, any nonprofit hospital or medical service corporation service contract, any health maintenance organization health benefit plan, and, to the extent permitted by federal law, any self-insured or other health benefit plan offered or issued to an individual or group in this state.

FINANCE

ORIGINAL

H.163

AN ACT RELATING TO THE PUBLIC COUNSEL FOR HEALTH INSURANCE.

HOUSE OF REPRESENTATIVES

January 28 1997

Introduced by Representative Kehler of Pomfret.

Read the first time and referred to Committee on Health & Welfare

Donald E. Mc Clure Clerk

House of Representatives,
3/27, 1997
ENTERED ON THE CALENDAR FOR NOTICE.
FIRST ASS'T CLERK

House of Representatives,
3/27/97
THE BILL APPEARING ON THE CALENDAR FOR NOTICE, AFFECTING [illegible] UNDER THE RULES [illegible] COMMITTEE ON WAYS AND MEANS.
FIRST ASS'T CLERK

House of Representatives,
4/5, 1997
ENTERED ON THE CALENDAR FOR NOTICE.
FIRST ASS'T CLERK

House of Representatives,
4/3, 1997
THE BILL APPEARING ON THE CALENDAR FOR NOTICE CARRYING AN APPROPRIATION, UNDER THE RULES WAS REFERRED TO THE COMMITTEE ON APPROPRIATIONS.
FIRST ASS'T CLERK

House of Representatives,
4/16, 1997
ENTERED ON THE CALENDAR FOR NOTICE.
2nd ASS'T CLERK

REPRESENTATIVES
4/11 1997
RECOM. OF
HHW + W+M
Approp
HHW
Approp.
H+W, A3
O, AMD
1ST CLERK

Pending the question, Shall the bill be read a third time, Rep. Young of Orwell moved that the bill be comm. to the Comm. on Commerce.

Pending the question, Shall the bill be committed to the Com. on Commerce

Mrs Seibert of Norwich demanded the Yeas and Nays, which [illegible] by the Constitution

The Clerk proceeded to call the roll and the question was decided in the negative. Y-57, N-73

Thereupon, third reading was ordered.

4/13/97

Taken up and pending third reading of the bill, Mr. Koch et al of Barre Town moved that the bill be amended [illegible] Third

Pending the question, Koch Amendment

Mr. Arrien of Bennington demanded the Yeas and Nays, which [illegible] by the Constitution

The clerk proceeded to call the roll and the question was decided in the negative

Yes 57, No 80

Taken up and pending third reading of the bill, Mr. Aswod of Burl moved that the bill be amended which was ~~agreed to, on a division, ...~~ ~~Thereupon, the bill was read the third time and passed.~~

Taken up and pending third reading of the bill, Mr. Buchholz of Georgia moved that the bill be amended which was lost ~~agreed to, on a division~~. Thereupon, the bill was read the third time and ...

Pending the question, Shall the Bill Pass

Mr. Porier of Bauer demanded the Yeas and Nays, which demand was sustained by the Constitutional number.

The clerk proceeded to call the roll and the question was decided in the affirmative Yea 76 No 64

[signature]

SENATE CHAMBER

4/24 1997

READ AND REFERRED TO

Finance COMMITTEE

[signature]

ASSISTANT - SECRETARY

SENATE CHAMBER

3/20 1998

ENTERED ON CALENDAR FOR NOTICE.

Robert H. Gibson

SECRETARY

[redacted]

SENATE CHAMBER

3/20 1998

ON MOTION OF SEN. Rivers

THE RULES WERE SUSPENDED AND THE BILL WAS TAKEN UP FOR IMMEDIATE CONSIDERATION.

[signature]

ASSISTANT - SECRETARY

Thereupon, pending 2nd reading, on mot. of Sen Rivers, the bill was recommitted to Health & Welfare w/ rpt of Finance intact under Rule Suspension. [signature]

SENATE CHAMBER

4/2 1998

ENTERED ON CALENDAR FOR NOTICE.

[signature]

ASSISTANT - SECRETARY

SENATE CHAMBER

4/2 1998

The Bill being on the calendar for notice and carrying an appropriation, under the Rule, was referred to the Committee on Appropriations.

[signature]

ASSISTANT - SECRETARY

SENATE CHAMBER

4/15 1998

ENTERED ON CALENDAR FOR NOTICE.

[signature]

ASSISTANT - SECRETARY

SENATE CHAMBER

4/15 1998

ON MOTION OF SEN. Shunk

THE RULES WERE SUSPENDED AND THE BILL WAS TAKEN UP FOR IMMEDIATE CONSIDERATION.

[signature]

ASSISTANT - SECRETARY

SENATE CHAMBER

4/15 1998

Reported favorably with Recommendation(s) Proposal(s) of Amendment, read the second time, and thereupon the Recommendation(s) Proposals(s) of Amendment ~~was/were agreed to and Third Reading ordered.~~ of Finance was withdrawn;

ASSISTANT - SECRETARY

Thereupon, Sens Bartlett & Hendy moved to substitute an Amendment for the Rpt. of Approp., which was agreed to on a roll call, Yeas 18 Nays 11;

Thereupon, the rpt of Approp., as substituted, was agreed to;

Thereupon the rpt of H&W, as amended was agreed to; and

Thereupon, Sens Hooker & Snelling moved that the Senate Prop. of Amend. be amended, which was agreed to;

Thereupon, Sen Ritchie moved to amend the Senate Prop. of Amend., which was agreed to on a roll call, Yeas 20 Nays 9 and 3rd reading ordered.

[signature]

SENATE CHAMBER

4/16 19 98

Taken up and pending Third Reading.

Sen. Riehle moved to [redacted]

[redacted]

amend the Senate prop. of

ASSISTANT · SECRETARY

Amend, which was agreed to; Thereupon, Sen Dilluzi moved to amend the Senate Prop. of Amend, which amend. was ruled not germane as a pt of order raised by Sen Shumlin.

Thereupon, Sen Ide moved that the remarks of Sen Dilluzi be journalized, which was objected to and the question decided in the negative on a roll call Yeas 13 Nays 16;

Thereupon, the bill [redacted] was read the 3rd time and passed in conc.

with prop. of Amend on a roll call, Yeas 23 Nays 5

SENATE CHAMBER

4/16 19 98

UPON MOTION OF SEN. [redacted]

OF Shumlin

THE RULES WERE SUSPENDED AND THE BILL WAS ORDERED MESSAGED TO THE HOUSE FORTHWITH.

ASSISTANT · SECRETARY

UPON MOTION OF REP. Stacy OF Sut.

THE RULES WERE SUSP. & THE ACTION OF HOUSE ON THE BILL WAS ORDERED MESSAGED TO SEN. FORTHWITH & THE BILL DELVD. TO GOV. FORTHWITH.

ASST. CLERK

House of Representatives,

4/17, 1998

ENTERED ON THE CALENDAR F R NOTICE.

FIRST ASS'T CLERK.

4/18/98

The Bill, appearing on the calendar for notice, was taken up under suspension of the rules, as moved by Mr. Trey of Burl.

Senate proposal [redacted] of amendment considered, and concurred in.