

1 TO THE HOUSE OF REPRESENTATIVES:

2 The Committee on Health Care to which was referred House Bill No. 585  
3 entitled “An act relating to health insurance reforms” respectfully reports that it  
4 has considered the same and recommends that the bill be amended by striking  
5 out all after the enacting clause and inserting in lieu thereof the following:

6 \* \* \* Health Insurer Governance and Executive Compensation \* \* \*

7 Sec. 1. 8 V.S.A. chapter 123 is amended to read:

8 CHAPTER 123. NONPROFIT HOSPITAL SERVICE CORPORATIONS

9 \* \* \*

10 § 4512. POWERS

11 (a) ~~Such~~ A hospital service corporation shall be a nonprofit sharing  
12 corporation without capital stock. It shall be maintained and operated solely  
13 for the benefit of ~~the~~ its subscribers ~~thereof~~ and shall ensure that benefits and  
14 services are balanced with the efficient and economical management of the  
15 corporation. A hospital service corporation shall not be authorized to pay  
16 money in lieu of hospital service. A person, partnership, association, or  
17 corporation shall not contract to furnish hospital service unless authorized ~~to~~ to  
18 do so pursuant to the provisions of this chapter. Corporations formed under  
19 the provisions of this chapter shall have the privileges and be subject to the  
20 provisions of Title 11B as well as the applicable provisions of this chapter. In

1 the event of a conflict between the provisions of Title 11B and the provisions  
2 of this chapter, the latter shall control.

3 \* \* \*

4 § 4513. PERMIT TO ENGAGE IN BUSINESS; FOREIGN  
5 CORPORATIONS

6 (a) ~~At least three fourths of the board of directors of a corporation~~  
7 ~~organized under this chapter shall be composed of subscribers and members of~~  
8 ~~the public. The remainder may be providers. The subscriber members of the~~  
9 ~~board shall comprise at least a majority of the board. A corporation organized~~  
10 ~~under this chapter shall provide for the election of its board of directors at a~~  
11 ~~publicly announced meeting. As used in this section, “provider” means any~~  
12 ~~person who is a provider of hospital or medical services, or who is an~~  
13 ~~employee, director, trustee, or representative of a provider of such services.~~

14 [Repealed.]

15 \* \* \*

16 § 4513a. BOARD OF DIRECTORS

17 (a) Definitions. As used in this section:

18 (1) “Provider” means any person who is a provider of hospital or  
19 medical services, or who is an employee, director, trustee, or representative of  
20 a provider of such services.

1           (2) “Representative of the public” means any member of the board of  
2           directors appointed by the Governor. A representative of the public may be a  
3           member of the public, a subscriber, or a provider.

4           (b) Composition. At least three-fourths of the board of directors of a  
5           corporation organized under this chapter shall be composed of subscribers and  
6           members of the public. The remainder may be providers. The subscriber  
7           members of the board shall comprise at least a majority of the board. A  
8           corporation organized under this chapter shall provide for the election of its  
9           board of directors at a publicly announced meeting.

10          (c) Representatives of the public.

11           (1) Two voting members of the board, but in no event less than one-  
12           sixth of the board of directors, shall be representatives of the public appointed  
13           by the Governor. Unless otherwise specified in this chapter, a representative  
14           of the public shall have the same rights and responsibilities as any other  
15           member of the board of directors.

16           (2) The initial term of one representative of the public shall be two years  
17           and the initial term of the other representative of the public shall be three years.  
18           If there are more than two representatives of the public, their initial terms shall  
19           be divided as equally as possible between the two initial term lengths.  
20           Thereafter, each representative of the public appointed by the Governor to

1 succeed a representative of the public shall serve a three-year term and shall  
2 serve until a successor is appointed.

3 (3) A representative of the public shall be terminated only by the  
4 appointing authority, by conclusion of the appointed term, or by voluntary  
5 resignation.

6 (4) If a vacancy occurs prior to the conclusion of the three-year term,  
7 whether by termination, resignation, or otherwise, the Governor shall appoint a  
8 new representative of the public to complete the term.

9 (d) Committees.

10 (1) The board of directors may create one or more committees and may  
11 appoint members of the board, including the representatives of the public, to  
12 serve on them.

13 (2) The board shall create a compensation committee to review and  
14 recommend to the full board for approval all compensation packages offered to  
15 the corporation's officers and executives.

16 (A) The compensation committee shall be composed of two or more  
17 members, who shall serve at the pleasure of the board of directors.

18 (B) At least two representatives of the public shall be voting  
19 members of the compensation committee.

1       (e) Guiding principles for representatives of the public. In discharging the  
2       duties of a director, including as a member of a committee, each representative  
3       of the public:

4             (1) shall, in determining what the representative of the public reasonably  
5       believes to be in the best interests of the hospital service corporation, consider  
6       the effects of any action or inaction on:

7                     (A) the subscribers of the hospital service corporation;

8                     (B) the community and societal considerations of the State of  
9       Vermont, including the principles for health care reform expressed in 18  
10       V.S.A. § 9371; and

11                    (C) the goal that the hospital service corporation’s benefits and  
12       services should be provided at minimum cost and under efficient and  
13       economical management of the corporation;

14             (2) may consider any other relevant factors and the interests of any other  
15       group that the representative of the public determines are appropriate to  
16       consider; and

17             (3) shall not be required to give priority to the interests of any particular  
18       person or group described in subdivision (1) or (2) of this subsection over the  
19       interests of any other person or group.



1     § 4516a. EXECUTIVE COMPENSATION

2           (a) As used in this section:

3                 (1) “Compensation” means total cash compensation, including base  
4                 salary and annual incentive compensation.

5                 (2) “Executives” means the president, chief executive officer, chief  
6                 medical officer, chief administrative officer, chief fiscal officer, vice  
7                 presidents, and all functionally equivalent roles in a hospital service  
8                 corporation.

9                 (b)(1) On or before July 1, 2026, and prior to approving any changes to the  
10                 compensation of any executive after that date, each hospital service  
11                 corporation shall file with the Commissioner of Financial Regulation a  
12                 statement sworn to by the chair of the corporation’s board of directors and the  
13                 president of the corporation that includes the following information regarding  
14                 compensation paid to executives of the corporation:

15                         (A) all compensation benchmarks utilized in connection with  
16                         establishing or awarding compensation for each of the corporation’s  
17                         executives, including information used by any consultant, vendor, or other  
18                         third party retained by the corporation;

19                         (B) a detailed compensation survey or peer group data used by the  
20                         corporation or by any consultant, vendor, or other third party retained by the

1 corporation to establish compensation benchmarks or otherwise to establish or  
2 award compensation for each of the corporation’s executives; and

3 (C) if any bonus or variable compensation was awarded or paid for the  
4 prior fiscal year, the criteria used to evaluate whether that compensation should  
5 be paid or awarded and the specific results that supported the payment.

6 (2) All information provided pursuant to this subsection shall be  
7 sufficiently detailed to allow for a comprehensive examination of the  
8 benchmarks and to enable the Commissioner or designee to perform  
9 independent computations to evaluate the benchmarks provided.

10 (c) The Commissioner may require the corporation to modify a group  
11 described in subdivision (b)(2) of this section if, in the Commissioner’s  
12 discretion, the group contains entities that are not sufficiently similar to the  
13 corporation in terms of size, business, operations, nonprofit status, or other  
14 factors.

15 (d) The Commissioner may retain at the corporation’s expense such outside  
16 consultants and other experts as are reasonably necessary to assist the  
17 Commissioner in evaluating the materials provided pursuant to this section.  
18 Any persons so retained shall be under the direction and control of the  
19 Commissioner and shall act in a purely advisory capacity.

20 (e) Nothing in this section shall be construed to preclude a corporation  
21 from segregating and designating any materials provided to the Commissioner

1 under this section as confidential due to content that is proprietary, privileged,  
2 or otherwise confidential under Vermont law, and the Commissioner shall  
3 maintain the confidentiality of the information as appropriate under the Public  
4 Records Act.

5 \* \* \*

6 Sec. 2. HOSPITAL SERVICE CORPORATIONS; IMPLEMENTATION OF  
7 AMENDMENTS TO 8 V.S.A. CHAPTER 123

8 Not later than September 1, 2026, each hospital service corporation  
9 operating in this State on July 1, 2026, shall amend its bylaws to comply with  
10 the amendments to 8 V.S.A. chapter 123 as set forth in Sec. 1 of this act. The  
11 hospital service corporation shall file its amended bylaws with the  
12 Commissioner of Financial Regulation for review and approval.

13 \* \* \* Expanding Access to Association Health Plans \* \* \*

14 Sec. 3. 8 V.S.A. § 4041 is amended to read:

15 § 4041. GROUP HEALTH INSURANCE POLICIES; DEFINITIONS

16 (a) As used in this section:

17 (1) “Employees” includes the officers, managers, and employees of the  
18 employer; the partners, if the employer is a partnership; the officers, managers,  
19 and employees of subsidiary or affiliated corporations of a corporation  
20 employer; and the individual proprietors, partners, and employees of

1 individuals and firms, the business of which is controlled by the insured  
2 employer through stock ownership, contract, or otherwise.

3 (2) “Employer” may be deemed to include any municipal or  
4 governmental entity or officer, or the appropriate officer for an unincorporated  
5 town or gore or for the Unified Towns and Gores of Essex County, as well as  
6 private individuals, partnerships, and corporations.

7 (b) Group health insurance is a form of health insurance that covers one or  
8 more persons, with or without their dependents, that is issued upon the  
9 following basis:

10 (1)(A) Under a policy issued to an employer, who is deemed the  
11 policyholder, insuring at least one employee of the employer, for the benefit of  
12 persons other than the employer.

13 (B) In accordance with section 3368 of this title, an employer  
14 domiciled in a jurisdiction other than Vermont that has more than 25  
15 certificate-holder employees whose principal worksite and domicile is in  
16 Vermont and that is defined as a large group in its own jurisdiction and under  
17 the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1304,  
18 as amended by the Health Care and Education Reconciliation Act of 2010,  
19 Pub. L. No. 111-152, may purchase insurance in the large group health  
20 insurance market for its Vermont-domiciled certificate-holder employees.

1 (2)(A) Under a policy issued:

2 (i) to an association, a trust, or one or more trustees of a fund  
3 established by one or more associations otherwise eligible for the issuance of a  
4 policy under this subdivision (2) and maintained, directly or indirectly, by one  
5 or more associations for the benefit of its members or a contract or plan issued  
6 by such an association or trust; or

7 (ii) by a “multiple employer welfare arrangement” that constitutes  
8 an “employer,” as those terms are defined in the Employee Retirement Income  
9 Security Act of 1974, as amended, and accompanying U.S. Department of  
10 Labor regulations and guidance.

11 ~~(B)(i) The association or associations shall have:~~

12 ~~(I) a minimum of 100 persons at the time of incorporation or~~  
13 ~~formation;~~

14 ~~(II) been organized and maintained in good faith for purposes~~  
15 ~~other than that of obtaining insurance;~~

16 ~~(III) been in active existence for at least one year; and~~

17 ~~(IV) a constitution and bylaws that provide that:~~

18 ~~(aa) the association or associations hold regular meetings~~  
19 ~~not less than annually to further purposes of the members;~~

20 ~~(bb) except for credit unions, the association or associations~~  
21 ~~collect dues or solicit contributions from members; and~~

1                   ~~(cc) the members constitute a majority of the voting power~~  
2                   ~~of the association for all purposes and have representation on the governing~~  
3                   ~~board and committees.~~

4                   ~~(ii)(I) The association or associations shall not be controlled by a~~  
5                   ~~health insurer, as evidenced by the operation of the association or associations.~~

6                   ~~(II) The following factors may be used as evidence to~~  
7                   ~~determine whether an association is a health insurer operated association;~~  
8                   ~~provided, however, that the presence or absence of one or more of these factors~~  
9                   ~~shall not serve to limit or be dispositive of such a determination:~~

10                   ~~(aa) common board members, officers, executives, or~~  
11                   ~~employees;~~

12                   ~~(bb) common ownership of the health insurer and the~~  
13                   ~~association, or of the association and another eligible group; and~~

14                   ~~(cc) common use of office space or equipment used by the~~  
15                   ~~health insurer to transact insurance. [Repealed.]~~

16                   ~~(C) An association's members shall have a shared or common~~  
17                   ~~purpose that is not primarily a business or customer relationship. [Repealed.]~~

18                   (D)(i) A policy issued by an association shall not insure persons other  
19                   than the members or employees of the association or associations, or  
20                   employees of members, or all of any class or classes of employees of the  
21                   association, associations, or members, together, in each case, with the

1 employees' or members' dependents, as applicable, for the benefit of persons  
2 other than the employee's employer.

3 (ii) A policy issued by an association shall insure all eligible  
4 persons, except those who reject coverage in writing.

5 (E) An association shall not use the solicitation of insurance as the  
6 primary method of obtaining new members.

7 (F) If a health insurer collects membership fees or dues on behalf of  
8 an association, the health insurer shall disclose to the members of the  
9 association that the health insurer is billing and collecting membership fees and  
10 dues on behalf of the association.

11 (3)(A) Under a policy issued to a trust, or to one or more trustees of a  
12 fund established and maintained, directly or indirectly, by:

13 (i) two or more employers;

14 (ii) one or more labor unions or similar employee organizations;

15 or

16 (iii) one or more employers and one or more labor unions or  
17 similar employee organizations.

18 (B)(i) A policy under this subdivision (3) must be issued to the trust  
19 or trustees for the purpose of insuring all of the employees of the employers or  
20 all of the members of the unions or organizations, or all of any class or classes  
21 of employees or members, together, in each case, with the employees' or

1 members' dependents, as applicable, for the benefit of persons other than the  
2 employers or the unions or organizations.

3 (ii) A policy issued to a trust shall insure all eligible persons,  
4 except those who reject coverage in writing.

5 (4) Under a policy issued to any other substantially similar group that, in  
6 the discretion of the Commissioner, may be subject to the issuance of a group  
7 accident and sickness policy or contract.

8 Sec. 4. 8 V.S.A. § 4043 is amended to read:

9 § 4043. ASSOCIATION HEALTH PLANS

10 (a)(1) As used in this section, “association health plan” means ~~a policy~~  
11 ~~issued to an association; to a trust; or to one or more trustees of a fund~~  
12 ~~established, created, or maintained for the benefit of the members of one or~~  
13 ~~more associations or a contract or plan issued by an association or trust or by a~~  
14 ~~multiple employer welfare arrangement as defined in the Employee Retirement~~  
15 ~~Income Security Act of 1974, 29 U.S.C. § 1001 et seq.~~

16 (2) ~~No association health plan shall be issued, offered, or renewed in~~  
17 ~~this State to any person other than an association that was formed or could~~  
18 ~~have been formed under the Employee Retirement Income Security Act of~~  
19 ~~1974, 29 U.S.C. § 1001 et seq., and accompanying U.S. Department of Labor~~  
20 ~~regulations and guidance, in each case, as in effect as of January 19, 2017 a~~  
21 group described in subdivision 4041(b)(2), (3), or (4) of this chapter.

1 (b) The Commissioner shall adopt rules pursuant to 3 V.S.A. chapter 25  
2 regulating association health plans in order to protect Vermont consumers and  
3 promote the stability of Vermont’s health insurance markets, to the extent  
4 permitted under federal law, including rules regarding licensure, solvency and  
5 reserve requirements, and rating requirements.

6 (c) ~~The~~ Notwithstanding any statute or rule to the contrary, the provisions  
7 of section sections 3661 and 4042 of this title shall apply to fully insured  
8 association health plans.

9 **Sec. 5. ASSOCIATION HEALTH PLANS; FEDERAL LANDSCAPE;**

10 **REPORT**

11 **On or before January 15, 2027, the Department of Financial Regulation**  
12 **shall report to the House Committee on Health Care and the Senate**  
13 **Committees on Health and Welfare and on Finance on the status of**  
14 **federal law regarding association health plans, including the extent to**  
15 **which federal law would allow for the expanded access to association**  
16 **health plans permitted beginning on January 1, 2028, pursuant to 8 V.S.A.**  
17 **§§ 4041 and 4043, as amended by Secs. 3 and 4 of this act.**

18 \* \* \* Expanding Access to Short-Term, Limited-Duration Plans \* \* \*

19 Sec. 6. 8 V.S.A. § 4053 is amended to read:

20 § 4053. SHORT-TERM, LIMITED-DURATION HEALTH INSURANCE

1 (a) As used in this section, “short-term, limited-duration health insurance”  
2 ~~means health insurance that provides medical, hospital, or major medical~~  
3 ~~expense benefits coverage pursuant to a policy or contract with a health insurer~~  
4 ~~and that has an expiration date specified in the policy or contract that is three~~  
5 ~~months or less after the original effective date of the policy or contract~~ has the  
6 same meaning as “short-term, limited-duration insurance” in 45 C.F.R.  
7 § 144.103.

8 (b) No person shall provide short-term, limited-duration health insurance  
9 coverage without a certificate of authority from the Commissioner to offer  
10 health insurance in this State unless the person is exempted by subdivision  
11 3368(a)(4) of this title.

12 (c) A short-term, limited-duration health insurance policy or contract shall  
13 ~~be nonrenewable, and a health insurer shall not issue a short-term, limited-~~  
14 ~~duration health insurance policy or contract to any person if the issuance would~~  
15 ~~result in the person being covered by short-term, limited-duration health~~  
16 ~~insurance coverage for more than three months in any 12-month period~~ not  
17 have a duration of longer than 12 months in total, taking into account any  
18 renewals or extensions.

19 (d) A policy or contract for short-term, limited-duration health insurance  
20 coverage shall display prominently in the policy or contract and in any  
21 application materials provided in connection with enrollment in that coverage,

1 in at least 14-point type, certain disclosures regarding the scope of short-term,  
2 limited-duration health insurance coverage, including the types of benefits and  
3 consumer protections that are and are not included. The Commissioner shall  
4 determine the specific disclosure language that shall be used in all short-term,  
5 limited-duration health insurance policies, contracts, and application materials  
6 and shall provide the language to the health insurers offering that coverage.

7 (e) The Commissioner shall adopt rules pursuant to 3 V.S.A. chapter 25:

8 (1) establishing the minimum financial, marketing, service, and other  
9 requirements for registration of a health insurer to provide short-term, limited-  
10 duration health insurance coverage to individuals in this State;

11 (2) requiring a health insurer seeking to provide short-term, limited-  
12 duration health insurance coverage to individuals in this State to file its rates  
13 and forms with the Commissioner for the Commissioner’s approval;

14 (3) requiring a health insurer seeking to provide short-term, limited-  
15 duration health insurance coverage to individuals in this State to file its  
16 advertising materials with the Commissioner for the Commissioner’s approval;

17 and

18 (4) establishing such other requirements as the Commissioner deems  
19 necessary to protect Vermont consumers and promote the stability of  
20 Vermont’s health insurance markets.

1 (f) The provisions of section 4063 of this title, and any rules adopted under  
2 that section, shall apply to short-term, limited-duration health insurance  
3 coverage.

4 \* \* \* Defining “High-Dollar Claims” for Claims Edit Purposes \* \* \*

5 Sec. 7. 18 V.S.A. § 9418a is amended to read:

6 § 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE  
7 TO CODING RULES

8 \* \* \*

9 (e)(1) Except as otherwise provided in subdivision (2) of this subsection,  
10 no health plan, contracting entity, covered entity, or payer shall subject any  
11 health care provider to prepayment coding validation edit review. As used in  
12 this subsection, “prepayment coding validation edit review” means any action  
13 by the health plan, contracting entity, covered entity, or payer, or by a  
14 contractor, assignee, agent, or other entity acting on its behalf, requiring a  
15 health care provider to provide medical record documentation in conjunction  
16 with or after submission of a claim for payment for health care services  
17 delivered, but before the claim has been adjudicated.

18 (2) Nothing in this subsection shall be construed to prohibit targeted  
19 prepayment coding validation edit review of a specific provider, provider  
20 group, or facility under certain circumstances, including evaluating ~~high-dollar~~  
21 claims exceeding \$25,000.00 per episode of care; verifying complex financial

1 arrangements; investigating member questions; conducting post-audit  
2 monitoring; addressing a reasonable belief of fraud, waste, or abuse; or other  
3 circumstances determined by the Commissioner through a bulletin or guidance.

4 \* \* \*

5 \* \* \* Site-Neutral Billing for Physical Therapy Services \* \* \*

6 Sec. 8. 18 V.S.A. § 9423 is added to read:

7 § 9423. SITE-NEUTRAL REIMBURSEMENT FOR PHYSICAL THERAPY

8 Each health plan shall establish and pay reimbursement amounts for all  
9 physical therapy items and services provided to its insureds that are uniform  
10 and consistent across all of the health plan’s contracts and fee schedules,  
11 except that a plan may reimburse different amounts for physical therapy items  
12 and services delivered in an inpatient setting. Health plans shall express each  
13 reimbursement amount as a percentage of the Medicare rate for the same item  
14 or service.

15 Sec. 9. SITE-NEUTRAL REIMBURSEMENT FOR PHYSICAL

16 THERAPY; IMPLEMENTATION REPORT

17 On or before March 1, 2027, each health insurer that is required to make  
18 site-neutral reimbursements for physical therapy items and services pursuant to  
19 18 V.S.A. § 9423, as added by Sec. 8 of this act, shall provide an update to the  
20 House Committee on Health Care and the Senate Committees on Health and  
21 Welfare and on Finance regarding its implementation of the site-neutral

1 reimbursements, any trends or other financial impacts it has identified so far as  
2 a result of implementation, and any recommendations regarding the enactment  
3 of additional site-neutral reimbursement requirements.

4 \* \* \* Eliminating Prescription Drug-Specific Out-of-Pocket Maximums \* \* \*

5 Sec. 10. 8 V.S.A. § 4092 is amended to read:

6 § 4092. PRESCRIPTION DRUG COVERAGE

7 (a) A health insurance plan shall not include an annual dollar limit on  
8 prescription drug benefits.

9 ~~(b) A health insurance plan shall limit a covered individual's out-of-pocket~~  
10 ~~expenditures for all prescription drugs to not more for self only and family~~  
11 ~~coverage per year than the minimum dollar amounts in effect under Section~~  
12 ~~223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self only and family~~  
13 ~~coverage, respectively. [Repealed.]~~

14 ~~(c)(1) For prescription drug benefits offered in conjunction with a high-~~  
15 ~~deductible health plan (HDHP), the plan shall not provide prescription drug~~  
16 ~~benefits until the expenditures applicable to the deductible under the HDHP~~  
17 ~~have met the amount of the minimum annual deductibles in effect for self only~~  
18 ~~and family coverage under Section 223(c)(2)(A)(i) of the Internal Revenue~~  
19 ~~Code of 1986 for self only and family coverage, respectively, except that a~~  
20 ~~plan may offer first-dollar prescription drug benefits to the extent permitted~~  
21 ~~under federal law.~~



1           (A) the total number of individuals and households that participated  
2           in the plan or arrangement in this State in the immediately preceding calendar  
3           year;

4           (B) the total number of employer groups that participated in the plan  
5           or arrangement in this State in the immediately preceding calendar year,  
6           specifying the total number of participating individuals in each participating  
7           employer group;

8           (C) if the person offers a plan or arrangement in other states, the total  
9           number of participants in the plan or arrangement nationally;

10          (D) any contracts the person has entered into with providers in this  
11          State who provide health care services to plan or arrangement participants;

12          (E) the total amount of fees, dues, or other payments collected by the  
13          person in the immediately preceding calendar year from individuals, employer  
14          groups, or others that participated in the plan or arrangement, specifying the  
15          percentage of fees, dues, or other payments retained by the person for  
16          administrative expenses;

17          (F) the total dollar amount of requests for reimbursement of health  
18          care costs or services that were submitted in this State in the immediately  
19          preceding calendar year by plan or arrangement participants or providers who  
20          provided health care services to plan or arrangement participants;

1           (G) the total dollar amount of requests for reimbursement of health  
2           care costs or services that were submitted in this State and were determined to  
3           qualify for reimbursement under the plan or arrangement in the immediately  
4           preceding calendar year;

5           (H) the total dollar amount of payments made to providers in this  
6           State in the immediately preceding calendar year for health care services that  
7           were provided to or received by plan or arrangement participants;

8           (I) the total dollar amount of reimbursements made to plan or  
9           arrangement participants in this State in the immediately preceding calendar  
10          year for health care services provided to or received by a plan or arrangement  
11          participant;

12          (J) the total number of requests for reimbursement of health care  
13          costs or services submitted in this State in the immediately preceding calendar  
14          year that were denied, expressed as a percentage of total reimbursement  
15          requests submitted in that calendar year, and the total number of  
16          reimbursement request denials that were appealed;

17          (K) the total dollar amount of health care expenses submitted in this  
18          State by plan or arrangement participants or providers in the immediately  
19          preceding calendar year that qualify for reimbursement pursuant to the plan or  
20          arrangement criteria but that, as of the end of that calendar year, have not been  
21          reimbursed, excluding any amounts that the plan or arrangement participants

1 incurring the health care costs must pay before receiving reimbursement under  
2 the plan or arrangement;

3 (L) the estimated number of plan or arrangement participants the  
4 person anticipates in this State in the next calendar year, specifying the number  
5 of individuals, households, employer groups, and employees;

6 (M) a list of other states in which the person offers a plan or  
7 arrangement;

8 (N) a list of any third parties, other than a licensed insurance  
9 producer, that are associated with or assist the person in offering or enrolling  
10 participants in this State in the plan or arrangement, copies of any training  
11 materials provided to a third party, and a detailed accounting of any  
12 commissions or other fees or remuneration paid to a third party in the  
13 immediately preceding calendar year for:

14 (i) marketing, promoting, or enrolling participants in a plan or  
15 arrangement offered by the person in this State; or

16 (ii) operating, managing, or administering a plan or arrangement  
17 offered by the person in this State;

18 (O) the total number of licensed insurance producers that are  
19 associated with or assist the person in offering or enrolling participants in this  
20 State in the plan or arrangement, the total number of participants enrolled in  
21 the plan or arrangement through a licensed insurance producer, copies of any

1 training materials provided to a producer, and a detailed accounting of any  
2 commissions or other fees or remuneration paid to a producer in the  
3 immediately preceding calendar year for marketing, promoting, or enrolling  
4 participants in a plan or arrangement offered by the person in this State;

5 (P) copies of any consumer-facing and marketing materials used in  
6 this State in promoting the person’s plan or arrangement, including plan or  
7 arrangement descriptions, benefit descriptions, and other materials that explain  
8 the plan or arrangement;

9 (Q) the name, mailing address, email address, and telephone number  
10 of an individual serving as a contact for the person in this State;

11 (R) a list of any parent companies, subsidiaries, and other names that  
12 the person has operated under at any time within the immediately preceding  
13 five calendar years; and

14 (S) an organizational chart of the person and a list of the officers and  
15 directors of the person; and

16 (2) a certification by an officer of the person that, to the best of the  
17 person’s good-faith knowledge and belief, the information submitted is  
18 accurate and satisfies the requirements of this subsection.

19 (b)(1) If a person subject to the requirements of subsection (a) of this  
20 section fails to submit the information required by that subsection, the  
21 submission is incomplete. The Commissioner shall make a determination of

1 completeness not later than 45 days after the submission is received. If the  
2 Commissioner has not informed the person of any deficiencies in the  
3 submission within 45 days after receiving the submission, the submission is  
4 considered complete.

5 (2)(A) If the Commissioner determines that a person has failed to  
6 comply with the requirements of subsection (a) of this section, the  
7 Commissioner shall:

8 (i) notify the person that the submission is incomplete and  
9 enumerate in the notification each deficiency found in the person’s submission;  
10 and

11 (ii) allow the person 30 days after notice of the incomplete  
12 submission to remedy the deficiency found in the submission.

13 (B) If the person does not remedy the deficiency within the 30-day  
14 period, the Commissioner may impose an administrative penalty not to exceed  
15 \$5,000.00 per day.

16 (C) If the person does not remedy the deficiency or deficiencies  
17 within 30 days after the initial administrative penalty is imposed, the  
18 Commissioner may issue a cease and desist order pursuant to section 2110 of  
19 this title.

20 (c) On or before April 1, 2027, and on or before each October 1 thereafter,  
21 the Commissioner shall:

