HOUSE COMMITTEE OF REFERENCE REPORT

_____ April 1, 2022

Chair of Committee Date

Committee on Health & Insurance.

After consideration on the merits, the Committee recommends the following:

HB22-1269 be amended as follows, and as so amended, be referred to the Committee on Appropriations with favorable recommendation:

Amend printed bill, page 3, after line 17 insert:

"(III) IF THE PERSON OFFERS A PLAN OR ARRANGEMENT IN OTHER STATES, THE TOTAL NUMBER OF PARTICIPANTS IN THE PLAN OR ARRANGEMENT NATIONALLY;

(IV) ANY CONTRACTS THE PERSON HAS ENTERED INTO WITH PROVIDERS IN THIS STATE THAT PROVIDE HEALTH-CARE SERVICES TO PLAN OR ARRANGEMENT PARTICIPANTS;".

Renumber succeeding subparagraphs accordingly.

Page 3, after line 23 insert:

"(VI) THE TOTAL DOLLAR AMOUNT OF CLAIMS OR REQUESTS FOR PAYMENT OR COVERAGE OF HEALTH-CARE COSTS OR SERVICES SUBMITTED IN THIS STATE IN THE IMMEDIATELY PRECEDING CALENDAR YEAR BY PARTICIPANTS IN THE PLAN OR ARRANGEMENT OR PROVIDERS THAT PROVIDED HEALTH-CARE SERVICES TO PLAN OR ARRANGEMENT PARTICIPANTS;

(VII) THE TOTAL DOLLAR AMOUNT OF CLAIMS OR REQUESTS FOR PAYMENT OR COVERAGE OF HEALTH-CARE COSTS OR SERVICES THAT WERE DETERMINED TO QUALIFY FOR PAYMENT OR COVERAGE UNDER THE PLAN OR ARRANGEMENT IN THE IMMEDIATELY PRECEDING CALENDAR YEAR;".

Renumber succeeding subparagraphs accordingly.

Page 3, line 24, after "PROVIDERS" insert "IN THIS STATE".

Page 4, line 2, after "PARTICIPANTS" insert "IN THIS STATE".

Page 4, after line 4 insert:

"(X) THE TOTAL NUMBER OF CLAIMS OR REQUESTS FOR PAYMENT OR COVERAGE OF HEALTH-CARE COSTS OR SERVICES SUBMITTED IN THIS STATE IN THE IMMEDIATELY PRECEDING CALENDAR YEAR THAT WERE DENIED, EXPRESSED AS A PERCENTAGE OF TOTAL CLAIMS OR REQUESTS SUBMITTED IN THAT CALENDAR YEAR, AND THE TOTAL NUMBER OF CLAIM OR REQUEST DENIALS THAT WERE APPEALED;

(XI) THE TOTAL AMOUNT OF HEALTH-CARE EXPENSES SUBMITTED BY PLAN OR ARRANGEMENT PARTICIPANTS OR PROVIDERS IN THIS STATE IN THE IMMEDIATELY PRECEDING CALENDAR YEAR THAT QUALIFY FOR PAYMENT OR COVERAGE PURSUANT TO THE PLAN OR ARRANGEMENT CRITERIA BUT THAT, AS OF THE END OF THAT CALENDAR YEAR, HAVE NOT BEEN PAID OR COVERED, EXCLUDING ANY AMOUNTS THAT THE PLAN OR ARRANGEMENT PARTICIPANTS INCURRING THE HEALTH-CARE COSTS MUST PAY BEFORE RECEIVING PAYMENTS OR COVERAGE UNDER THE PLAN OR ARRANGEMENT;".

Renumber succeeding subparagraphs accordingly.

Page 4, line 6, after "PARTICIPANTS" insert "IN THIS STATE".

Page 4, line 16, strike "PARTY, INCLUDING" and substitute "PARTIES, OTHER THAN".

Page 4, line 17, strike "IS ASSOCIATED WITH THE PERSON OR ASSISTS" and substitute "ARE ASSOCIATED WITH OR ASSIST".

Page 4, line 18, after "PARTICIPANTS" insert "IN THIS STATE".

Page 4, lines 19 and 20, strike "INCLUDING A PRODUCER,".

Page 4, lines 21 and 22, strike "PARTY, INCLUDING A PRODUCER," and substitute "PARTY".

Page 4, after line 26 insert:

"(XVI) THE TOTAL NUMBER OF PRODUCERS THAT ARE ASSOCIATED WITH OR ASSIST THE PERSON IN OFFERING OR ENROLLING PARTICIPANTS IN THIS STATE IN THE PLAN OR ARRANGEMENT, THE TOTAL NUMBER OF PARTICIPANTS ENROLLED IN THE PLAN OR ARRANGEMENT THROUGH A

PRODUCER, COPIES OF ANY TRAINING MATERIALS PROVIDED TO A PRODUCER, AND A DETAILED ACCOUNTING OF ANY COMMISSIONS OR OTHER FEES OR REMUNERATION PAID TO A PRODUCER IN THE IMMEDIATELY PRECEDING CALENDAR YEAR FOR MARKETING, PROMOTING, OR ENROLLING PARTICIPANTS IN A PLAN OR ARRANGEMENT OFFERED BY THE PERSON IN THIS STATE;".

Renumber succeeding subparagraphs accordingly.

Page 5, line 1, after "USED" insert "IN THIS STATE".

Page 5, line 9, after "YEARS;" add "AND".

Page 5, strike lines 12 through 16.

Page 6, strike lines 2 through 5 and substitute:

"(b) (I) IF THE COMMISSIONER DETERMINES THAT A PERSON FAILS TO COMPLY WITH THE REQUIREMENTS OF SUBSECTION (1) OF THIS SECTION:

(A) THE COMMISSIONER SHALL NOTIFY THE PERSON THAT THE SUBMISSION IS INCOMPLETE AND ENUMERATE IN THE NOTIFICATION EACH DEFICIENCY FOUND IN THE PERSON'S SUBMISSION; AND

(B) THE COMMISSIONER SHALL ALLOW THE PERSON THIRTY DAYS AFTER THE INITIAL FINE IS LEVIED TO REMEDY THE DEFICIENCY FOUND IN THE SUBMISSION.

(II) IF THE PERSON DOES NOT REMEDY THE DEFICIENCY WITHIN THE THIRTY-DAY PERIOD, THE COMMISSIONER MAY LEVY A FINE NOT TO EXCEED TEN THOUSAND DOLLARS PER DAY.

(III) IF THE PERSON DOES NOT REMEDY THE DEFICIENCY OR DEFICIENCIES WITHIN THIRTY DAYS AFTER THE INITIAL FINE IS LEVIED, THE COMMISSIONER MAY ISSUE A CEASE-AND-DESIST ORDER IN ACCORDANCE WITH SECTION 10-3-904.5.".

Page 6, strike lines 11 and 12 and substitute "ACCURATE AND EVIDENCE-BASED INFORMATION ABOUT THE PERSONS WHO SUBMITTED INFORMATION PURSUANT TO SUBSECTION (1) OF THIS SECTION, INCLUDING HOW CONSUMERS MAY FILE COMPLAINTS; AND".

Page 6, after line 19 insert:

"(5) THIS SECTION DOES NOT APPLY TO DIRECT PRIMARY CARE AGREEMENTS AS DEFINED IN ARTICLE 23 OF TITLE 6.".

Page 7, strike line 2 and substitute:

"(II) A PERSON DOES NOT REMEDY A DEFICIENCY OR DEFICIENCIES IN THE SUBMISSION REQUIRED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-107.4 (1) WITHIN THE THIRTY DAYS AFTER THE COMMISSIONER LEVIES AN INITIAL FINE PURSUANT TO SECTION 10-16-107.4 (2)(b);".

Page 1, line 101, strike "**UNAUTHORIZED PERSONS**" and substitute "**PERSONS NOT AUTHORIZED TO TRANSACT INSURANCE BUSINESS IN THIS STATE WHO ARE**".

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