Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

Senate Bill 811 (Senator Klausmeier)
Finance

Health Insurance and Discount Medical Plans - Vision Care Services and Materials

This bill prohibits a provider contract from requiring a provider to participate in a discount medical plan as a condition of participation in a fee-for-service provider panel. A carrier may not require a vision provider to accept reimbursement that is less than 80% of the usual and customary charge for vision care services or materials. A discount medical plan organization or discount drug plan organization may not (1) sell, market, or solicit a discount medical plan for vision care services or materials in which the determined charges to plan members, including discounts on vision care services or materials, do not comply with specified requirements or (2) use in its advertisements, marketing material, brochures, and discount cards the term "benefit" in a manner that could reasonably mislead a person into believing the plan was health insurance.

The bill takes effect June 1, 2015, and applies to all polices and contracts issued, delivered, or renewed in the State on or after October 1, 2015. For policies and contracts in effect on October 1, 2015, but not subject to renewal before October 1, 2016, the bill applies no later than October 1, 2016.

Fiscal Summary

State Effect: Potential minimal increase in special fund expenditures for the Maryland Insurance Administration to review policy contracts and forms to ensure compliance with the bill. Revenues are not affected.

Local Effect: None.

Small Business Effect: Meaningful for small business vision providers who may receive higher reimbursement under the bill.

Analysis

Bill Summary: Regarding provider contracts, the definition of "carrier" is expanded to include a discount medical plan organization that, independent from or on behalf of another carrier, determines charges, including discounts, to plan members for vision care services or materials. The definition of "provider contract" is expanded to include a contract under which the provider agrees to provide health care services *or materials* to enrollees *or plan members*.

Current Law: "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other financial consideration provides the right to receive discounts on specified medical services from specified providers. "Discount medical plan organization" means an entity that contracts directly or indirectly with providers or provider networks to provide medical services at a discount to plan members and determines the charge to plan members. "Plan member" means any individual who pays fees, dues, charges, or other financial consideration for the right to receive the benefits of a discount medical plan or a discount drug plan.

A discount medical or drug plan organization may not (1) use specified terms in its advertisements, marketing material, brochures, and discount cards that could reasonably mislead a person into believing the plan was health insurance; (2) have restrictions on access to plan providers, including waiting periods and notification periods; (3) pay providers any fees for medical services, pharmaceutical supplies, prescription drugs, or medical equipment and supplies, except when also serving as a third-party administrator; (4) refuse to modify the method of payment for membership on request, unless a specific method of payment is required as a term of the plan and was agreed to in writing in advance; (5) if membership is billed on a monthly basis, refuse to permit membership to terminate without financial penalty on no more than 30 calendar days' written notice; or (6) continue electronic fund transfer payments more than 30 calendar days after a written request for termination or require the member to notify more than one entity that electronic fund transfer should be terminated.

A provider contract may not contain a provision that requires a provider (1) as a condition of participation in a non-HMO provider panel, to participate in an HMO provider panel or (2) as a condition of participation in a fee-for-service dental provider panel, to participate in a capitated dental provider panel.

A carrier may not include in a vision provider contract a provision that requires a vision provider to (1) provide health care services that are not covered services at a fee set by the carrier; (2) provide discounts on materials that are not covered benefits; or (3) as a condition of participation in a fee-for-service vision panel, to participate in a capitated vision provider panel. A vision provider contract may require a vision provider, as a

condition of participating in a non-HMO vision provider panel, to participate in a Medicaid managed care organization.

Additional Information

Prior Introductions: None.

Cross File: HB 1190 (Delegate Kipke) - Health and Government Operations.

Information Source(s): Department of Budget and Management, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

Fiscal Note History: First Reader - March 16, 2015
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