SENATE BILL 811

C3 5lr1754
CF 5lr2936

By: **Senator Klausmeier**
Introduced and read first time: February 20, 2015
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

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

FOR the purpose of prohibiting certain organizations from using in their advertisements, marketing material, brochures, and discount cards a certain term in a certain context; prohibiting certain organizations from selling, marketing, or soliciting a certain plan under certain circumstances; prohibiting certain provider contracts from containing a certain provision; prohibiting certain carriers from including in certain contracts a certain provision; defining certain terms; altering certain defined terms; providing for the application of this Act; and generally relating to the provision of discounts on vision care services and vision care materials by health insurance carriers and discount medical plan organizations.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 14–601(a) and (e)
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–601(g), 14–606, and 15–112.2
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

14–601.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

(a) In this subtitle the following words have the meanings indicated.

(e) "Discount medical plan organization" means an entity that:

(1) contracts directly or indirectly with providers or provider networks to provide medical services at a discount to plan members; and

(2) determines the charge to plan members.

(g) "Medical services" means any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including physician care, outpatient services, ambulance services, dental care services, vision care services **OR MATERIALS**, mental health services, substance abuse services, chiropractic services, podiatric care services, and laboratory services.

14–606.

A discount medical plan organization and a discount drug plan organization may not:

(1) use in their advertisements, marketing material, brochures, and discount cards the term "insurance" except:

(i) in the name of an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization whose corporate name includes the word "insurance";

(ii) when comparing the discount medical plan or discount drug plan to insurance or otherwise distinguishing the discount medical plan or discount drug plan from insurance; or

(iii) as otherwise provided in this subtitle;

(2) use in their advertisements, marketing material, brochures, and discount cards the terms "health plan", "coverage", "copay", "copayments", "preexisting conditions", "guaranteed issue", "premium", "ppo", "preferred provider organization", **"BENEFIT",** or other terms in a context that could reasonably mislead a person into believing the discount medical plan or discount drug plan was health insurance;

(3) have restrictions on access to discount medical plan or discount drug plan providers, including waiting periods and notification periods;

(4) pay providers any fees for medical services, pharmaceutical supplies, prescription drugs, or medical equipment and supplies, except that a discount medical plan organization or a discount drug plan organization that also has an active registration under

Title 8, Subtitle 3 of this article may continue to pay fees to providers in its capacity as a third party administrator;

(5) refuse to modify the method of payment for membership in a discount medical plan or a discount drug plan on request, unless a specific method of payment is required as a term of the discount medical plan or the discount drug plan and was agreed to in writing in advance;

(6) 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**]**

(7) (i) continue electronic fund transfer as a method of payment more than 30 calendar days after a written request for termination of electronic fund transfer has been made; or

(ii) require the member to notify more than one entity that is either the discount medical plan organization or the discount drug plan organization or an entity identified by the discount medical plan organization or the discount drug plan organization that electronic fund transfer should be terminated**; OR**

(8) SELL, MARKET, OR SOLICIT A DISCOUNT MEDICAL PLAN FOR VISION CARE SERVICES OR VISION CARE MATERIALS IN WHICH THE DETERMINED CHARGES TO PLAN MEMBERS, INCLUDING DISCOUNTS ON VISION CARE SERVICES OR VISION CARE MATERIALS, DO NOT COMPLY WITH § 15–112.2 OF THIS ARTICLE.

15–112.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Capitated dental provider panel" means a provider panel for one or more dental plan organizations offering contracts only for dental services reimbursed on a capitated basis for certain services.

(3) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization; **[**or**]**

(iv) a dental plan organization**; OR**

(V) 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 VISION CARE MATERIALS.

(4) "DISCOUNT MEDICAL PLAN" HAS THE MEANING STATED IN § 14–601 OF THIS ARTICLE.

(5) "DISCOUNT MEDICAL PLAN ORGANIZATION" HAS THE MEANING STATED IN § 14–601 OF THIS ARTICLE.

[(4)**](6)** "Enrollee" means a person entitled to health care benefits from a carrier.

[(5)**](7)** "Fee–for–service dental provider panel" means a provider panel for one or more dental plan organizations, insurers, or nonprofit health service plans offering contracts only for dental services reimbursed on a full or discounted fee–for–service basis.

[(6)**](8)** "HMO provider panel" means a provider panel for one or more health maintenance organizations.

[(7)**](9)** "Managed care organization" has the meaning stated in § 15–101 of the Health – General Article.

[(8)**](10)** "Non–HMO provider panel" means a provider panel for one or more nonprofit health service plans or insurers.

(11) "PLAN MEMBER" HAS THE MEANING STATED IN § 14–601 OF THIS ARTICLE.

[(9)**](12)** "Provider" has the meaning stated in § 19–701 of the Health – General Article.

[(10)**](13)** "Provider contract" means a contract:

(i) between a provider and a carrier, an affiliate of a carrier, or an entity that contracts with a provider to serve a carrier; and

(ii) under which the provider agrees to provide health care services **OR MATERIALS** to enrollees **OR PLAN MEMBERS**.

[(11)**](14)** "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to enrollees.

(15) "VISION CARE MATERIALS" MEANS LENSES, DEVICES CONTAINING LENSES, PRISMS, LENS TREATMENTS AND COATINGS, CONTACT LENSES, ORTHOPTICS, AND VISION TRAINING AND PROSTHETIC DEVICES TO CORRECT, RELIEVE, OR TREAT DEFECTS OR ABNORMAL CONDITIONS OF THE HUMAN EYE OR ADNEXA.

(b) (1) A provider contract may not contain a provision that requires a provider:

(i) as a condition of participating in a non–HMO provider panel, to participate in an HMO provider panel; **[**or**]**

(ii) as a condition of participating in a fee–for–service dental provider panel, to participate in a capitated dental provider panel**; OR**

(III) AS A CONDITION OF PARTICIPATING IN A FEE–FOR–SERVICE PROVIDER PANEL, TO PARTICIPATE IN A DISCOUNT MEDICAL PLAN.

(2) Notwithstanding paragraph (1) of this subsection, a provider contract may contain a provision that requires a provider, as a condition of participating in a non–HMO provider panel, an HMO provider panel, or a dental provider panel, to participate in a managed care organization.

(c) (1) This subsection does not apply to a provider contract for a dental provider panel.

(2) Each provider contract shall disclose the carriers comprising each provider panel.

(d) (1) This subsection does not apply to a provider contract for a dental provider panel.

(2) If a provider contract includes more than one schedule of applicable fees, the provider contract may not contain a provision that requires a provider as a condition of participation to accept each schedule of applicable fees included in the provider contract.

(3) If a provider rejects a schedule of applicable fees, the provider contract may not require the provider to treat the enrollees of the carriers that reimburse the provider in accordance with any of the rejected schedules of applicable fees.

(4) Notwithstanding the provisions of paragraph (1) of this subsection, a provider contract may include a provision that requires a provider, as a condition of participation, to accept each schedule of applicable fees for a carrier that is not affiliated through common ownership with the entity arranging the provider panel.

(e) If a provider elects to terminate participation on a provider panel, the provider shall:

(1) notify the carrier at least 90 days before the date of termination; and

(2) for at least 90 days after the date of the notice of termination, continue to furnish health care services to an enrollee of the carrier for whom the provider was responsible for the delivery of health care services before the notice of termination.

(f) A provider contract may not contain a provision that requires a participating dental provider, as a condition of continued participation in a capitated dental provider panel or a fee–for–service dental provider panel, to accept an added, revised, or amended fee schedule that contains a lower fee.

(g) (1) In this subsection, "covered services" means health care services that are reimbursable under a policy or contract for dental services between an enrollee and a carrier, subject to any contractual limitations on benefits, including deductibles, copayments, or frequency limitations.

(2) A carrier may not include in a dental provider contract a provision that requires a dental provider to provide health care services that are not covered services at a fee set by the carrier.

(h) (1) In this subsection, "covered services" means health care services **OR MATERIALS** that are reimbursable under a policy or contract for vision **CARE** services **OR VISION CARE MATERIALS** between an enrollee and a carrier, subject to any contractual limitations on benefits, including deductibles, copayments, or frequency limitations.

(2) A carrier may not include in a vision provider contract a provision that requires a vision provider:

(i) to provide health care services that are not covered services at a fee set by the carrier; or

(ii) to provide discounts on materials that are not covered benefits.

(3) (i) A carrier may not include in a vision provider contract a provision that requires a vision provider, as a condition of participation in a fee–for–service vision provider panel, to participate in a capitated vision provider panel.

(ii) Notwithstanding subparagraph (i) of this paragraph, a vision provider contract may contain a provision that requires a vision provider, as a condition of participating in a non–HMO vision provider panel or an HMO vision provider panel to participate in a managed care organization.

(4) A CARRIER MAY NOT INCLUDE IN A VISION PROVIDER CONTRACT A PROVISION THAT REQUIRES A VISION PROVIDER TO ACCEPT REIMBURSEMENT

FOR VISION CARE SERVICES OR VISION CARE MATERIALS THAT IS LESS THAN 80% OF THE USUAL AND CUSTOMARY CHARGE FOR VISION CARE SERVICES OR VISION CARE MATERIALS.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies and contracts issued, delivered, or renewed in the State on or after October 1, 2015, or, for policies and contracts in effect in the State on October 1, 2015, but not subject to renewal before October 1, 2016, no later than October 1, 2016.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2015.