

HOUSE BILL 1190

C3

5lr2936
CF SB 811

By: **Delegate Kipke**

Introduced and read first time: February 24, 2015

Assigned to: Rules and Executive Nominations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance and Discount Medical Plans – Vision Care Services and**
3 **Materials**

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

13 BY repealing and reenacting, without amendments,
14 Article – Insurance
15 Section 14–601(a) and (e)
16 Annotated Code of Maryland
17 (2011 Replacement Volume and 2014 Supplement)

18 BY repealing and reenacting, with amendments,
19 Article – Insurance
20 Section 14–601(g), 14–606, and 15–112.2
21 Annotated Code of Maryland
22 (2011 Replacement Volume and 2014 Supplement)

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

25 **Article – Insurance**

26 14–601.

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



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

2 (e) “Discount medical plan organization” means an entity that:

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

5 (2) determines the charge to plan members.

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

11 14–606.

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

14 (1) use in their advertisements, marketing material, brochures, and
15 discount cards the term “insurance” except:

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

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

22 (iii) as otherwise provided in this subtitle;

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

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

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

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

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

7 (6) if membership is billed on a monthly basis, refuse to permit
8 membership to terminate without financial penalty on no more than 30 calendar days'
9 written notice; [or]

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

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

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

21 15–112.2.

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

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

26 (3) “Carrier” means:

27 (i) an insurer;

28 (ii) a nonprofit health service plan;

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

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

31 **(V) A DISCOUNT MEDICAL PLAN ORGANIZATION THAT,**
32 **INDEPENDENT FROM OR ON BEHALF OF ANOTHER CARRIER, DETERMINES CHARGES,**

1 INCLUDING DISCOUNTS, TO PLAN MEMBERS FOR VISION CARE SERVICES OR VISION
2 CARE MATERIALS.

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

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

7 [(4)](6) "Enrollee" means a person entitled to health care benefits from a
8 carrier.

9 [(5)](7) "Fee-for-service dental provider panel" means a provider panel
10 for one or more dental plan organizations, insurers, or nonprofit health service plans
11 offering contracts only for dental services reimbursed on a full or discounted fee-for-service
12 basis.

13 [(6)](8) "HMO provider panel" means a provider panel for one or more
14 health maintenance organizations.

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

17 [(8)](10) "Non-HMO provider panel" means a provider panel for one or
18 more nonprofit health service plans or insurers.

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

21 [(9)](12) "Provider" has the meaning stated in § 19-701 of the Health –
22 General Article.

23 [(10)](13) "Provider contract" means a contract:

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

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

28 [(11)](14) "Provider panel" means the providers that contract either
29 directly or through a subcontracting entity with a carrier to provide health care services to
30 enrollees.

1 **(15) “VISION CARE MATERIALS” MEANS LENSES, DEVICES**
2 **CONTAINING LENSES, PRISMS, LENS TREATMENTS AND COATINGS, CONTACT**
3 **LENSES, ORTHOPTICS, AND VISION TRAINING AND PROSTHETIC DEVICES TO**
4 **CORRECT, RELIEVE, OR TREAT DEFECTS OR ABNORMAL CONDITIONS OF THE HUMAN**
5 **EYE OR ADNEXA.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect June
9 1, 2015.