HOUSE BILL 1211

C3 6lr1693
CF SB 932

By: **Delegates Kipke, Chang, Hayes, Krebs, McMillan, and Oaks**
Introduced and read first time: February 12, 2016
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Discount Vision Plans – Provider Contracts

FOR the purpose of prohibiting a contract between a discount medical plan organization and a provider of certain vision care services from limiting or specifying certain fees or requiring the provider to participate in one discount vision plan as a condition for participating in another discount vision plan or in a certain provider panel; requiring the contract to require that certain changes to the contract be made in a certain manner and to disclose each discount that the provider is required to accept from a discount vision plan member for certain services; providing that a certain provider of vision care services may elect to reject certain schedules of discounts under certain circumstances; prohibiting certain provider contracts from containing a provision that conditions participation in a certain provider panel on participation in a discount vision plan; defining certain terms; providing for the application of this Act; and generally relating to discount vision plans.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–601, 14–606, and 15–112.2(b)
Annotated Code of Maryland
(2011 Replacement Volume and 2015 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–112.2(a)(1) and (11)
Annotated Code of Maryland
(2011 Replacement Volume and 2015 Supplement)

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

Article – Insurance

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

14–601.

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

(b) (1) "Discount drug plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other financial consideration paid by or on behalf of a plan member, provides the right to receive discounts on specified pharmaceutical supplies, prescription drugs, or medical equipment and supplies from specified providers.

(2) "Discount drug plan" does not include:

(i) a business arrangement or contract in which the fees, dues, charges, and other financial consideration paid by or on behalf of a plan member consist only of:

1. a payment made directly to a provider as a dispensing or transactional fee in connection with the purchase of pharmaceutical supplies, prescription drugs, or medical equipment and supplies that are subject to a discount; or

2. an administrative or processing fee paid by anyone other than a plan member to a provider in connection with that provider's provision of discounts to plan members; or

(ii) a patient assistance program that:

1. is sponsored, offered, or provided for by a pharmaceutical manufacturer; and

2. is not provided in exchange for fees, dues, charges, or other financial consideration.

(c) "Discount drug plan organization" means an entity that:

(1) contracts directly or indirectly with providers or provider networks to provide pharmaceutical supplies, prescription drugs, or medical equipment and supplies at a discount to plan members; and

(2) determines the charge to plan members.

(d) "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other financial consideration paid by or on behalf of a plan member, provides the right to receive discounts on specified medical services from specified providers.

(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.

(F) "DISCOUNT VISION PLAN" MEANS A DISCOUNT MEDICAL PLAN THAT PROVIDES VISION CARE SERVICES TO PLAN MEMBERS.

[(f)**] (G)** "Hospital services" has the meaning stated in § 19–201 of the Health – General Article.

[(g)**] (H)** "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, mental health services, substance abuse services, chiropractic services, podiatric care services, and laboratory services.

[(h)**] (I)** "Medicare prescription drug plan" means a plan that provides a Medicare Part D prescription drug benefit in accordance with the requirements of the federal Medicare Modernization Act.

[(i)**] (J)** "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.

[(j)**] (K)** "Provider" means:

(1) any person or institution which is contracted, directly or indirectly, with a discount medical plan organization to provide medical services to plan members; or

(2) any person or institution which is contracted, directly or indirectly, with a discount drug plan organization to provide pharmaceutical supplies, prescription drugs, or medical equipment and supplies to plan members.

[(k)**] (L)** "State prescription drug plan" means any discount plan operated by a State agency.

(M) (1) "VISION CARE SERVICES" MEANS SERVICES, INCLUDING MEDICAL EYE CARE SERVICES, PROVIDED BY A PROVIDER WITHIN THE SCOPE OF THE PROVIDER'S LICENSE TO PRACTICE.

(2) "VISION CARE SERVICES" INCLUDES THE PROVISION OF VISION CARE MATERIALS, INCLUDING LENSES, DEVICES CONTAINING SPECTACLE LENSES, CONTACT LENSES, PRISMS, LENS TREATMENTS AND COATINGS, AND ORTHOPTIC OR

PROSTHETIC DEVICES TO CORRECT, RELIEVE, OR TREAT DEFECTS OR ABNORMAL CONDITIONS OF THE HUMAN EYE OR ADNEXA.

14–606.

(A) 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", 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.

(B) (1) A CONTRACT BETWEEN A DISCOUNT MEDICAL PLAN ORGANIZATION AND A PROVIDER OF VISION CARE SERVICES:

(I) MAY NOT LIMIT OR SPECIFY THE FEE THAT THE PROVIDER MAY CHARGE FOR VISION CARE SERVICES THAT ARE NOT INCLUDED IN THE DISCOUNT VISION PLAN;

(II) MAY NOT REQUIRE THE PROVIDER TO PARTICIPATE IN ONE DISCOUNT VISION PLAN AS A CONDITION FOR PARTICIPATING IN ANOTHER DISCOUNT VISION PLAN OR A FEE–FOR–SERVICE PROVIDER PANEL;

(III) SHALL REQUIRE THAT ANY CHANGE IN REQUIRED DISCOUNTS, REIMBURSEMENT RATES, OR OTHER TERMS OF THE CONTRACT BE MADE ONLY WITH THE SIGNED CONSENT OF THE PROVIDER; AND

(IV) SHALL DISCLOSE EACH DISCOUNT THAT A PROVIDER IS REQUIRED TO ACCEPT FROM A DISCOUNT VISION PLAN MEMBER FOR EACH DISCOUNT VISION SERVICE COVERED UNDER THE CONTRACT.

(2) A PROVIDER OF VISION CARE SERVICES THAT CONTRACTS WITH A DISCOUNT MEDICAL PLAN ORGANIZATION THAT PROVIDES MORE THAN ONE SCHEDULE OF DISCOUNTS MAY ELECT TO REJECT ONE OR MORE OF THE SCHEDULES.

15–112.2.

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

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

(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 VISION PLAN AS DEFINED IN § 14–601 OF THIS ARTICLE.

(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.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all provider contracts subject to this Act entered into or renewed in the State on or after October 1, 2016.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2016.