

PROJECT HISTORY - 2006

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT (#98)

1. Description of the project, issues addressed, etc.

This model law was drafted to address an issue of increasing concern to state departments of insurance – the rising number of consumer complaints about discount medical cards. This new model establishes a comprehensive regulatory scheme to enable regulators to track these entities and ensure that these entities are legitimate and not fraudulent; sets out uniform disclosure requirements to ensure that consumers know what they are buying; sets out uniform marketing and advertising requirements to ensure that these cards are not being marketed to consumers in a fraudulent or misleading way; and includes strict provider contracting requirements to ensure network adequacy and the actual existence of network providers to provide the promised discounts to consumers.

2. Name of group responsible for draft the model:

Health Discount Plan Working Group of the Health Insurance and Managed Care (B) Committee and the Health Insurance and Managed Care (B) Committee

States Participating:

Florida, Chair	Montana
Alaska	Nebraska
Arkansas	Nevada
Colorado	Oklahoma
District of Columbia	Ohio
Illinois	Oregon
Indiana	South Dakota
Kansas	Utah
Maryland	Vermont
Minnesota	Wisconsin

3. Project authorized by what charge and date first given to the group:

The following charge given in 2005:

Review issues surrounding health discount plans and draft a model law or regulation, as appropriate. Report by Winter 2005 Meeting.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The model was drafted by the Working Group. Numerous interested parties participated, including industry representatives, such as the America's Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), CIGNA, WellPoint, Pacificare, Aetna, the Consumer Health Alliance (CHA), the National Association of Health Underwriters (NAHU), the National Association of Dental Plans (NADP); the Pharmaceutical Care Management Association (PCMA); prescription drug manufacturer representatives, such as the Pharmaceutical Research and Manufacturers of America (PhRMA), Caremark and Merck; consumer representatives, such as the American Diabetes Association and Families USA; and other interested parties, such as the Council for Affordable Health Insurance (CAHI) and the National Association of Insurance and Financial Advisors (NAIFA).

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

There have been nine drafts of the proposed new model. Each draft was circulated for comment to interested parties prior to discussion at NAIC quarterly meetings and during Working Group telephone conference calls. In addition, all drafts of the proposed model were posted on the NAIC web site. Throughout the drafting process comments from various interest groups and organizations were received and discussed by the Working Group.

6. A discussion of the significant issues (items of some controversy) raised during the due process and the group's response.

There were several significant issues that arose during the drafting of this model. The first issue considered the model's scope – whether licensed health carriers and their affiliates would be subject to the requirements of this model and, if so, which of the requirements. Over the course of several meetings and several telephone conference calls and after considerable discussion, the Working Group decided that licensed health carriers that would be considered a discount medical plan organization (DMPO), as that term is defined in the model, would only be required to comply with specific provisions in the model that related to marketing requirements, refund requirements, form filing requirements and advertising and disclosure requirements. The Working Group decided that because health carriers are already subject to the jurisdiction of the insurance commissioner, they would not be required to obtain a license or comply with other provisions of the new model, such as the examination and investigation requirements, bonding requirements and optional solvency requirements, that they are already subject to as licensed health carriers. With respect to their affiliates, the Working Group decided that these entities would be subject to all of the requirements in the model. The Working Group members were concerned that, if not regulated in this manner, affiliates could be established and used as a vehicle to circumvent the model's provisions and, as such, become a potential source of fraudulent activity.

The next significant issue concerned whether the model would include a comprehensive licensing scheme or a streamlined registration scheme. Those arguing for a comprehensive licensing scheme stated that the provisions requiring background checks and fingerprinting helped to ferret out fraudulent operators because it requires any individual involved in the DMPO's operations to be identified and to submit to a background check and fingerprinting. As such, an individual involved in operating a DMPO that violated the law previously would be flagged even if the DMPO is operating under a different name. Those supporting a streamlined registration scheme stated that this regulatory scheme was more appropriate for non-risk-bearing entities, like DMPOs. They also argued that most states that have recently enacted legislation regulating DMPOs have chosen a streamlined registration scheme that did not include background checks and fingerprinting. After extensive discussion of this issue, the Working Group decided to retain the licensing scheme with its background check and fingerprinting requirements. Some working group members were concerned that deleting these requirements altogether was not appropriate for a model law. A NAIC model law should include the strongest possible protections for consumers. As a compromise, the Working Group agreed to include some options with respect to the fingerprinting and background checks. States can decide whether to include these requirements based on their staffing and financial resources.

Another issue the working group debated concerned whether the new model should impose minimum capital requirements on DMPOs. Those arguing in favor of imposing such requirements asserted that requiring DMPOs to have a minimum net worth reinforces the legitimacy of the entity. Those arguing against including such a requirement stated that it was inappropriate for a non-risk-bearing entity. As a compromise, the Working Group decided to make the minimum net worth requirement optional. The working group also added a bonding requirement to ensure that if there was a problem with a DMPO that there would be some resources that could be used for the benefit of discount medical plan members.

Another issue debated extensively throughout the drafting process concerned “bundling”. As part of their marketing and sale strategy, some DMPOs bundle (combine) the discount product with non-discount products. This combined product is sold to the consumer as package. Some working group members were concerned that this practice had the potential to confuse consumers as to the actual cost of what they were buying. To address this problem and after extensive debate, the Working Group decided to retain a provision in the model that requires DMPOs to disclose the cost of the discount product to the consumer when the discount product is sold with any other product. Also, after extensive debate, the Working Group decided to add a provision to the new model to address the situation when a licensed health carrier is a DMPO and is selling an insured product with a discount product. If the discount product is incidental to the insured product, then the health carrier is not required to disclose the cost of the discount product. In addition, the health carrier also would not be subject to the model's refund requirements. However, if the discount product is more than incidental, then the health carrier must disclose the cost of the discount product to the consumer just as other DMPOs that are not licensed health carriers are required to do and is also subject to the refund requirements.

Another issue that arose during the drafting process concerned whether to include discount prescription drug plan organizations within the scope of the model and, if so, what would be the appropriate scheme for regulating them. While acknowledging that discount prescription drug plan organizations have not been the subject of as many complaints as DMPOs, some Working Group members expressed a desire to include these entities within the scope of the model in order to be able to track and identify them in the event there was a problem. After extensive discussion, the Working Group decided to include discount prescription drug plan programs within the scope of the model as an optional section. In addition, the Working Group decided to require these entities to be subject to a similar regulatory scheme as licensed health carriers that

are DMPOs. They are not required to obtain a license but must designate a compliance officer for ensuring the entity's compliance with law and provide that name to the insurance commissioner.

After the Working Group adopted the proposed model in May 2006, there was additional discussion at the Health Insurance and Managed Care (B) Committee level at the 2006 NAIC Summer National Meeting. The Committee postponed voting on the model to provide an opportunity for interested parties to submit a final round of comments to the Committee outlining their concerns and to present proposals to address those concerns. Based on the comments, the Committee held a conference call in August 2006 to consider revisions to the proposed model as presented by the Working Group. The Committee adopted revisions to the model that include giving states the option of choosing whether to require a DMPO to obtain a license or certificate of registration. The Committee also revised the bundling provision to include an option for states to choose from with respect to requirements for marketers and DMPOs to disclose the fees for each discount medical plan whenever a discount medical plan is sold together with any other product.

7. Any other important information (e.g., amending an accreditation standard).

None.