

DISCOUNT MEDICAL PLAN ORGANIZATION MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as the Discount Medical Plan Organization Model Act.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in Section 16 of this Act, may want to change the short title of this Act to the “Discount Medical Plan and Prescription Drug Plan Organization Model Act.”

Section 2. Purpose

The purpose of this Act is to promote the public interest by establishing standards for discount medical plan organizations to protect consumers from unfair or deceptive marketing, sales or enrollment practices and to facilitate consumer understanding of the role and function of discount medical plan organizations in providing access to medical or ancillary services.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in Section 16 of this Act, may want to include a reference to discount prescription drug plan organizations in this section.

Section 3. Definitions

For purposes of this Act:

- A. “Affiliate” means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.
- B. “Ancillary services” includes, but is not limited to, audiology, dental, vision, mental health, substance abuse, chiropractic and podiatry services.
- C. “Commissioner” means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

- D. “Control” or “controlled by” or “under common control with” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by [insert reference in state law that is equivalent to Section 4K of the NAIC Insurance Holding Company System Regulatory Act] that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination that control exists in fact, notwithstanding the absence of a presumption to that effect.
- E. (1) “Discount medical plan” means a business arrangement or contract in which a person, in exchange for fees, dues, charges or other consideration, offers access for its members to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount medical plan from those providers.
- (2) “Discount medical plan” does not include:
- (a) A plan that does not charge a membership or other fee to use the plan’s discount medical card; or
- (b) Any product regulated under [insert reference to applicable state law].
- F. (1) “Discount prescription drug plan” means a business arrangement or contract in which a person, in exchange for fees, dues, charges or other consideration provides access for its plan members to providers of pharmacy services and the right to receive discounts on pharmacy services provided under the discount prescription drug plan from those providers.
- (2) “Discount prescription drug plan” does not include:
- (a) A plan that does not charge a membership or other fee to use the plan’s discount prescription drug card;
- (b) A patient access program; or
- (c) A Medicare prescription drug plan or any product regulated under [insert reference to applicable state law].

Drafting Note: A state should adopt Subsection F only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided Section 16 of this Act.

- G. “Discount medical plan organization” means an entity that, in exchange for fees, dues, charges or other consideration, provides access for discount medical plan members to providers of medical or ancillary services and the right to receive medical or ancillary services from those providers at a discount. It is the organization that contracts with providers, provider networks or other discount medical plan organizations to offer access to medical or ancillary services at a discount and determines the charge to discount medical plan members.
- H. “Discount prescription drug plan organization” means an entity that, in exchange for fees, dues, charges or other consideration, provides access for discount prescription drug plan members to providers of pharmacy services and the right to receive pharmacy services from those providers at a discount. It is the organization that contracts with providers, pharmacy networks or other discount prescription drug plan organizations to offer access to pharmacy services at a discount and determines the charge to discount prescription drug plan members.

Drafting Note: A state should adopt Subsection H only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

- I. (1) “Facility” means an institution providing medical or ancillary services or a health care setting.
- (2) “Facility” includes, but is not limited to:
 - (a) A hospital or other licensed inpatient center;
 - (b) An ambulatory surgical or treatment center;
 - (c) A skilled nursing center;
 - (d) A residential treatment center;
 - (e) A rehabilitation center; and
 - (f) A diagnostic, laboratory or imaging center.
- J. “Health care professional” means a physician, pharmacist or other health care practitioner who is licensed, accredited or certified to perform specified medical or ancillary services within the scope of his or her license, accreditation, certification or other appropriate authority and consistent with state law.
- K. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or medical or ancillary services.

Drafting Note: States that license health maintenance organizations pursuant to other statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- L. “Marketer” means a person or entity that markets, promotes, sells or distributes a discount medical plan, including a private label entity that places its name on and markets or distributes a discount medical plan pursuant to a marketing agreement with a discount medical plan organization.
- M. (1) “Medical services” means any maintenance care of, or preventive care for, the human body or care, service or treatment of an illness or dysfunction of, or injury to, the human body.
- (2) “Medical services” includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services and medical equipment and supplies.
- (3) “Medical services” does not include pharmacy services or ancillary services.
- N. “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 Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

Drafting Note: A state should adopt Subsection N only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

- O. (1) “Member” means any individual who pays fees, dues, charges or other consideration for the right to receive the benefits of a discount medical plan [or discount prescription drug plan].
- (2) “Member” does not include any individual who enrolls in a patient access program.

Drafting Note: A state should include the reference to discount prescription drug plan in Subsection O (1) and the provisions of Section O (2) if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

- P. “Patient access program” means a voluntary program sponsored by a pharmaceutical manufacturer, or a consortium of pharmaceutical manufacturers, that provides free or discounted health care products directly to low income or uninsured individuals either through a discount card or direct shipment.

Drafting Note: A state adopt Subsection P only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

- Q. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.
- R. “Pharmacy services” includes pharmaceutical supplies and prescription drugs.

Drafting Note: A state should adopt Subsection R only if the state decides to include discount prescription drug plan organizations within the scope of this Act as provided in Section 16 of this Act.

- S. “Provider” means any health care professional or facility that has contracted, directly or indirectly, with a discount medical plan organization to provide medical or ancillary services to members.
- T. “Provider network” means an entity that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider to provide medical or ancillary services to members.

Section 4. Applicability and Scope

- A. This Act applies to all discount medical plan organizations doing business in [or from] this state.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in Section 16 of this Act, may want to include a reference to discount prescription drug plan organizations in Subsection A.

- B. A discount medical plan organization that is a health carrier licensed pursuant to [insert reference to state insurance code or other applicable state statute]:
 - (1) Is not required to obtain a [license] [certificate of registration] under Section 5 of this Act, except that any of its affiliates that operate as a discount medical plan organization in this state shall obtain a [license] [certificate of registration] under Section 5 of this Act and comply with all other provisions of this Act; but
 - (2) Is required to comply with Sections 9, 10, 11, 12, and 13 of this Act and report, in the form and manner as the commissioner may require, any of the information described in Section 15B(2) (3) or (4) of this Act that is not otherwise already reported.

Section 5. [Licensing] [Registration] Requirements

Drafting Note: This section provides two options for a state to choose from when deciding what regulatory scheme to establish for those persons wishing to operate in [or from] the state as a discount medical plan organization. Option 1 sets out the requirements that must be satisfied to obtain and maintain a license to operate as a discount medical plan organization in [or from] the state. Option 2 sets out the requirements that must be satisfied to obtain and maintain a certificate of registration to operate as a discount medical plan organization in [or from] the state. Depending on which regulatory scheme is chosen a state should use the term “license” or “certificate of registration”, as appropriate, wherever the term is referenced in other sections of this Act.

Option 1. Licensing Requirements

Drafting Note: This option is for those states that want to require persons wishing to operate in [or from] the state as a discount medical plan organization to obtain a license from the commissioner before doing so.

- A. Before doing business in [or from] this state as a discount medical plan organization, a person other than an individual:
 - (1) Shall be authorized to transact business in this state under [insert reference to applicable state law]; and
 - (2) Shall obtain a license from the commissioner to operate as a discount medical plan organization.
- B. Except as provided in Subsection C, each application for a license to operate as a discount medical plan organization:
 - (1) Shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant; and

- (2) Shall demonstrate, set forth or be accompanied by the following, if applicable:
- (a) The applicable fees required under [insert reference to appropriate section in state law];
 - (b) A copy of the organization documents of the applicant, such as the articles of incorporation, including all amendments;
 - (c) A copy of the applicant’s bylaws or other enabling documents that establish organizational structure;
 - (d) The applicant’s federal identification number, business address and mailing address;
 - (e) (i) A list of names, addresses, official positions and biographical information of the individuals who are responsible for conducting the applicant’s affairs, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the officers, contracted management company personnel and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant; and
 - (ii) A disclosure in the listing of the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant’s affairs and the discount medical plan organization, including any possible conflicts of interest;
 - (f) A complete biographical statement, on forms prescribed by the commissioner, [an independent investigation report and a set of fingerprints, as provided in [insert reference to applicable section in state law],] with respect to each individual identified under Subparagraph (e) of this paragraph;
 - (g) A statement generally describing the applicant, its facilities and personnel and the medical or ancillary services for which a discount will be made available under the discount medical plan;
 - (h) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical or ancillary services to members;
 - (i) A copy of the form of any contract made or arrangement to be made between the applicant and any individual listed in Subparagraph (e) of this paragraph;
 - (j) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant’s behalf of any function, including marketing, administration, enrollment, [investment management] and subcontracting for the provision of medical or ancillary services to members;
 - (k) A copy of the applicant’s most recent financial statements audited by an independent certified public accountant, except that, subject to the approval of the commissioner, an applicant that is an affiliate of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity may submit the audited financial statement of the parent entity and a written guaranty that the minimum capital requirements required under Section 6 of this Act will be met by the parent entity instead of the audited financial statement of the applicant;

Drafting Note: States should include Subparagraph (k) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of licensure.

- (l) A description of the proposed methods of marketing, including, but not limited to, describing the use of marketers, use of the Internet, sales by telephone, and use of salespersons to market the discount medical plan benefits;
 - (m) A description of the member complaint procedures to be established and maintained by the applicant;
 - (n) The name and address of the applicant's [insert state name] statutory agent for service of process, notice or demand, or if not domiciled in this state, a power of attorney duly executed by the applicant, appointing the commissioner and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all law process in any legal action or proceeding against the discount medical plan organization on a cause of action arising in this state may be served; and
 - (o) Any other information the commissioner may reasonably require.
- C. (1) Upon application to and approval by the commissioner and payment of the applicable fees under [insert reference to appropriate sections in state law], a discount medical plan organization that holds a current license or other form of authority from another state to operate as a discount medical plan organization, at the commissioner's discretion, may not be required to submit the information required under Subsection B in order to obtain a license under this section if the commissioner is satisfied that the other state's requirements, at a minimum, are equivalent to those required under Subsection B or the commissioner is satisfied that the other state's requirements are sufficient to protect the interests of the residents of this state.
- (2) Whenever the discount medical plan organization loses its license or other form of authority in that other state to operate as a discount medical plan organization, or is the subject of any disciplinary administrative proceeding related to the organization's operating as a discount medical plan organization in that other state, the discount medical plan organization shall immediately notify the commissioner.
- D. After the receipt of an application filed pursuant to Subsection B or Subsection C, the commissioner shall review the application and notify the applicant of any deficiencies in the application.
- E. Within ninety (90) days after the date of receipt of a completed application, the commissioner shall:
- (1) Issue a license if the commissioner is satisfied that the applicant has met the following:
 - (a) The requirements of Subsection B or Subsection C have been met;
 - (b) The applicant has the required minimum capital in accordance with Section 6 of this Act; and

Drafting Note: States should include Subparagraph (b) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of licensure.

- (c) The ownership, control and management of the applicant are competent and trustworthy and possess managerial experience that would make the proposed operation of the discount medical plan organization beneficial to discount medical plan members; or

Drafting Note: In making a determination under Subparagraph (c), the commissioner may want to consider, for example, whether the applicant or an officer or manager of the applicant: (1) is not financially responsible; (2) does not have adequate expertise or experience to operate a medical discount plan organization; or (3) is not of good character. Among the factors that the commissioner may consider in making the determination is whether the applicant or an affiliate or a business formerly owned or managed by the applicant or an officer or manager of the applicant has had a previous application for a license, or other authority, to operate as any entity regulated by the commissioner, denied, has had such license or other authority revoked, suspended or terminated for cause, or is under investigation for or has been found in violation of a statute or regulation in another jurisdiction within the previous 5 years.

- (2) Disapprove the application and state the grounds for disapproval.
- F. Prior to licensure by the commissioner, each discount medical plan organization shall establish an Internet website in order to conform to the requirements of Section 11B of this Act.

- G. (1) A license is effective for one (1) year, unless prior to its expiration the license is renewed in accordance with this subsection or suspended or revoked in accordance with Subsection H.

Drafting Note: The one-year licensure term is optional. States should determine on a case-by-case basis the length of any license that is issued under this section.

- (2) At least ninety (90) days before a license expires, the discount medical plan organization shall submit:
- (a) A renewal application form; and
 - (b) The renewal fee.
- (3) The commissioner shall renew the license of each holder that meets the requirements of this Act and pays the appropriate renewal fee required by [insert reference to appropriate section in state law].
- H. (1) The commissioner may suspend the authority of a discount medical plan organization to enroll new members or refuse to renew or revoke a discount medical plan organization's license if the commissioner finds that any of the following conditions exist:
- (a) The discount medical plan organization is not operating in compliance with this Act;
 - (b) The discount medical plan organization does not have the minimum net worth as required under Section 6 of this Act;

Drafting Note: States should include Subparagraph (b) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of licensure.

- (c) The discount medical plan organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising;
 - (d) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or
 - (e) The continued operation of the discount medical plan organization would be hazardous to its members.
- (2) If the commissioner has cause to believe that grounds for the non-renewal, suspension or revocation of a license exists, the commissioner shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to renew or suspension or revocation and may pursue a hearing on the matter in accordance with the provisions of the [insert reference to state Administrative Procedure Act].
- (3) When the license of a discount medical plan organization is non-renewed, surrendered or revoked, the discount medical plan organization shall proceed, immediately following the effective date of the order of revocation or, in the case of a non-renewal, the date of expiration of the license, to wind up its affairs transacted under the license. The discount medical plan organization shall not engage in any further advertising, solicitation, collecting of fees or renewal of contracts.
- (4) (a) The commissioner shall, in its order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its license to enroll members.
- (b) The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

- (c) The license of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The commissioner shall not grant the request for reinstatement if the commissioner finds that the circumstances for which the suspension occurred still exist or are likely to recur.
- I. In lieu of suspending or revoking a discount medical plan organization's license under Subsection H, whenever the discount medical plan organization has been found to have violated any provision of this Act, the commissioner may:
 - (1) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; and
 - (2) Impose a monetary penalty of not less than \$100 for each violation, but not to exceed an aggregate penalty of \$75,000.
- J. Each licensed discount medical plan organization shall notify the commissioner immediately whenever the discount medical plan organization's license, or other form of authority, to operate as a discount medical plan organization in another state is suspended, revoked or non-renewed in that state.
- K. A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a license under this Act as a discount medical plan organization.

Option 2. Registration Requirements

Drafting Note: This option is for those states that want to require persons wishing to operate in [or from] the state as a discount medical plan organization to obtain a certificate of registration from the commissioner before doing so.

- A. Before doing business in [or from] this state as a discount medical plan organization, a person other than an individual:
 - (1) Shall be authorized to transact business in this state under [insert reference to applicable state law]; and
 - (2) Shall obtain a certificate of registration from the commissioner to operate as a discount medical plan organization.
- B. Each application for a certificate of registration to operate as a discount medical plan organization:
 - (1) Shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant;
 - (2) Shall be accompanied by the applicable fees required under [insert reference to appropriate section in state law];
 - (3) Shall include information on whether:
 - (a) A previous application for a certificate of registration has been denied, revoked, suspended or terminated for cause; and
 - (b) The applicant is under investigation for or the subject of any pending action or has been found in violation of a statute or regulation in any jurisdiction within the previous five (5) years; and
 - (4) Shall include information, as the commissioner may require, that permits the commissioner, after reviewing all of the information submitted pursuant to this subsection, to make a determination that the applicant:

- (a) Is financially responsible;
 - (b) Has adequate expertise or experience to operate a discount medical plan organization;
and
 - (c) Is of good character.
- C. After the receipt of an application filed pursuant to Subsection B, the commissioner shall review the application and notify the applicant of any deficiencies in the application.
- D. Within ninety (90) days after the date of receipt of a completed application, the commissioner shall:
- (1) Issue a certificate of registration if the commissioner is satisfied that the applicant has met the following:
 - (a) The requirements of Subsection B have been met; and
 - (b) The applicant has the required minimum capital in accordance with Section 6 of this Act;
or

Drafting Note: States should include Subparagraph (b) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of registration.

- (2) Disapprove the application and state the grounds for disapproval.
- E. Prior to issuance of a certificate of registration by the commissioner, each discount medical plan organization shall establish an Internet website in order to conform to the requirements of Section 11B of this Act.
- F. (1) A registration is effective for one (1) year, unless prior to its expiration it is renewed in accordance with this subsection or suspended or revoked in accordance with Subsection G.

Drafting Note: The one-year registration term is optional. States should determine on a case-by-case basis the length of any registration that is issued under this section.

- (2) At least ninety (90) days before a certificate of registration expires, the discount medical plan organization shall submit:
 - (a) A renewal application form; and
 - (b) The renewal fee.
 - (3) The commissioner shall renew the certificate of registration of each holder that meets the requirements of this Act and pays the appropriate renewal fee required by [insert reference to appropriate section in state law].
- G. (1) The commissioner may suspend the authority of a discount medical plan organization to enroll new members or refuse to renew or revoke a discount medical plan organization's certificate of registration if the commissioner finds that any of the following conditions exist:
- (a) The discount medical plan organization is not operating in compliance with this Act;
 - (b) The discount medical plan organization does not have the minimum net worth as required under Section 6 of this Act;

Drafting Note: States should include Subparagraph (b) only if they require a discount medical plan organization to have a minimum net worth under Section 6 of this Act as a condition of registration.

- (c) The discount medical plan organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising;
 - (d) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or
 - (e) The continued operation of the discount medical plan organization would be hazardous to its members.
 - (2) If the commissioner has cause to believe that grounds for the non-renewal, suspension or revocation of a certificate of registration exists, the commissioner shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to renew or suspension or revocation and may pursue a hearing on the matter in accordance with the provisions of the [insert reference to state Administrative Procedure Act].
 - (3) When the certificate of registration of a discount medical plan organization is non-renewed, surrendered or revoked, the discount medical plan organization shall proceed, immediately following the effective date of the order of revocation or, in the case of a non-renewal, the date of expiration of the certificate of registration, to wind up its affairs transacted under the certificate of registration. The discount medical plan organization shall not engage in any further advertising, solicitation, collecting of fees or renewal of contracts.
 - (4)
 - (a) The commissioner shall, in its order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its certificate of registration to enroll members.
 - (b) The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.
 - (c) The certificate of registration of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The commissioner shall not grant the request for reinstatement if the commissioner finds that the circumstances for which the suspension occurred still exist or are likely to recur.
- H. In lieu of suspending or revoking a discount medical plan organization's certificate of registration under Subsection G, whenever the discount medical plan organization has been found to have violated any provision of this Act, the commissioner may:
 - (1) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; and
 - (2) Impose a monetary penalty of not less than \$100 for each violation, but not to exceed an aggregate penalty of \$75,000.
- I. Each registered discount medical plan organization shall notify the commissioner immediately whenever the discount medical plan organization's certificate of registration, or other form of authority, to operate as a discount medical plan organization in another state is suspended, revoked or non-renewed in that state.
- J. A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a certificate of registration under this Act as a discount medical plan organization.

Section 6. Minimum Capital Requirements [Optional]

Drafting Note: This section is optional for those states that wish to require discount medical plan organizations to have and to maintain a minimum net worth as a condition of [licensure] [registration].

- A. Before the commissioner issues a [license] [certificate of registration] to any person required to obtain a license under Section 5 of this Act, the person seeking to operate a discount medical plan organization shall have a net worth of at least \$150,000.
- B. Each discount medical plan organization shall at all times maintain a net worth of at least \$150,000.
- C. At the commissioner’s discretion, the amounts in Subsections A and B may be adjusted annually for inflation.

Section 7. Surety Bond or Deposit Requirements

- A. Each [licensed] [registered] discount medical plan organization shall maintain in force a surety bond in its own name in an amount not less than \$35,000 to be used in the discretion of the commissioner to protect the financial interest of members. The bond shall be issued by an insurance company licensed to do business in this state.
- B. In lieu of the bond specified in Subsection A, a [licensed] [registered] discount medical plan organization may deposit and maintain deposited with the commissioner, or at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to the commissioner with at all times have a market value of not less than \$35,000.
- C. All income from a deposit made under Subsection B shall be an asset of the discount medical plan organization.
- D. Except for the commissioner, the assets or securities held in this state as a deposit under Subsection A or B shall not be subject to levy by a judgment creditor or other claimant of the discount medical plan organization.

Section 8. Examinations and Investigations

- A. The commissioner may examine or investigate the business and affairs of any discount medical plan organization to protect the interests of the residents of this state based on the following reasons, including, but not limited to, complaint indices, recent complaints, information from other states, or as the commissioner deems necessary.
- B. An examination or investigation conducted as provided in Subsection A shall be performed in accordance with the provisions of [insert reference to state law equivalent to the NAIC Model Law on Examinations].
- C. The commissioner may:
 - (1) Order any discount medical plan organization or applicant that operates a discount medical plan organization to produce any records, books, files, advertising and solicitation materials or other information; and
 - (2) Take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest.
- D. The discount medical plan organization or applicant that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount medical plan organization or applicant to pay the expenses is grounds for denial of a [license] [certificate of registration] to operate as a discount medical plan organization or revocation of a [license] [certificate of registration] to operate as a discount medical plan organization.

Section 9. Charges and Fees; Refund Requirements; Bundling of Services

- A. A discount medical plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount medical plan.
- B. (1) (a) If a member cancels his or her membership in the discount medical plan organization within the first thirty (30) days after the date of receipt of the written document for the discount medical plan described in Section 13D of this Act, the member shall receive a reimbursement of all periodic charges and the amount of any one-time processing fee that exceeds [\$30] upon return of the discount medical plan card to the discount medical plan organization.

Drafting Note: The maximum one-time processing fee amount of \$30 in Paragraph (1)(a) is a suggested amount.

- (b) (i) Cancellation occurs when notice of cancellation is given to the discount medical plan organization.
 - (ii) Notice of cancellation is deemed given when delivered by hand or deposited in a mailbox, properly addressed and postage prepaid to the mailing address of the discount medical plan organization or emailed to the email address of the discount medical plan organization.
 - (c) A discount medical plan organization shall return any periodic charge charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.
- (2) If the discount medical plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

Drafting Note: Subsection C below has two options for states to choose from with respect to bundling of services (i.e. – when a marketer or discount medical plan organization sells the discount medical plan with any other product). Option 1 is for those states that, in accordance with Option 1 in Section 10 of this Act, want discount medical plan organizations to file charges and forms with the commissioner for prior approval. Option 2 is for those states that decide not to adopt Option 1 in Section 10 of this Act or for those states that decide not to adopt Section 10 of this Act altogether.

Option 1.

Drafting Note: A state should choose this option for this subsection if the state decides to adopt Option 1 in Section 10 of this Act.

- C. When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the charges for each discount medical plan shall be provided in writing to the member.

Option 2.

Drafting Note: A state should choose this option for this subsection if the state decides not to adopt Option 1 in Section 10 of this Act or does not adopt Section 10 of this Act altogether.

- C. When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the marketer or discount medical plan organization shall:
 - (1) Provide the charges for each discount medical plan in writing to the member; or
 - (2) Reimburse the member for all periodic charges for the discount medical plan and all periodic charges for any other product if the member cancels his or her membership in accordance with Subsection B(1).
- D. Any discount medical plan organization that is a health carrier licensed pursuant to [insert reference in state insurance code or other applicable state statute] that provides a discount medical plan product that is incidental to the insured product is not subject to this section.

Section 10. Charge and Form Filing Requirements

Drafting Note: For those states that want to require discount medical plan organizations to file charges and forms with the commissioner, below are two options for this section that these states can choose from to impose such a requirement. Those states that do not want to impose such a requirement should not adopt either option. Option 1 is for those states that want to establish a prior approval system with respect to charges and forms to be used by a discount medical plan organization. Option 2 is for those states that want to establish a system under which a discount medical plan organization would be required to file with the commissioner for informational purposes all charges and forms to be used by the discount medical plan organization.

Option 1.

- A. (1) A discount medical plan organization shall file with the commissioner a list of all prospective member fees and charges associated with the discount medical plan.
- (2) Any fee or charge to members that is greater than an amount of [\$30] per month or [\$360] per year shall be submitted to the commissioner for approval prior to its use.

Drafting Note: The maximum amounts for the fees or charges in Paragraph (2) that a discount medical plan organization may charge are suggested amounts. Whatever amount a state chooses to use in this section should be consistent with the amount in Section 9B(1)(a) of this Act.

- (3) The discount medical plan organization has the burden of proof that a fee or charge bears a reasonable relationship to the benefits to be received by the member.
- B. (1) (a) All forms, including the form for the written document described under Section 13D of this Act, to be used by a discount medical plan organization shall first be filed with and approved by the commissioner.
- (b) Each form filed shall be identified in the manner as may be required by the commissioner.
- (2) (a) A charge or form shall be considered approved on the 60th day after its date of filing unless it has been previously disapproved by the commissioner.
- (b) The commissioner shall disapprove any charge or form that does not meet the requirements of this section or that is unreasonable, discriminatory, misleading, or unfair.
- (3) If a form filed pursuant to Paragraph (1) is disapproved, the commissioner shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.

Option 2.

- A. A discount medical plan organization shall file with the commissioner a list of all prospective member fees and charges associated with the discount medical plan.
- B. (1) In addition to Subsection A, a discount medical plan organization shall file all forms, including the form for the written document described under Section 13D of this Act, to be used by a discount medical plan organization with the commissioner prior to use.
- (2) Each form filed shall be identified in the manner as may be required by the commissioner.

Section 11. Provider Agreements; Provider Listing Requirements

- A. (1) A discount medical plan organization shall have a written provider agreement with all providers offering medical or ancillary services to its members. The written provider agreement may be entered into directly with the provider or indirectly with a provider network to which the provider belongs.
- (2) A provider agreement between a discount medical plan organization and a provider shall provide the following:
 - (a) A list of the medical or ancillary services and products to be provided at a discount;

- (b) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and
 - (c) That the provider will not charge members more than the discounted rates.
 - (3) A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers that:
 - (a) Contain the provisions described in Paragraph (2);
 - (b) Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; and
 - (c) Require the provider network to maintain an up-to-date list of its contracted providers and to provide the list on a monthly basis to the discount medical plan organization.
 - (4) A provider agreement between a discount medical plan organization and an entity that contracts with a provider network shall require that the entity, in its contract with the provider network, require the provider network to have written agreements with its providers that comply with Paragraph (3).
 - (5) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered.
- B.
 - (1) Each discount medical plan organization shall maintain on an Internet website page an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The Internet website address shall be prominently displayed on all of its advertisements, marketing materials, brochures and discount medical plan cards.
 - (2) This subsection applies to those providers with which the discount medical plan organization has contracted with directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

Section 12. Marketing Requirements

- A. A discount medical plan organization may market directly or contract with other marketers for the distribution of its product.
- B.
 - (1) The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling or distributing the discount medical plan.
 - (2) The agreement between the discount medical plan organization and the marketer shall prohibit the marketer from using advertising, marketing materials, brochures and discount medical plan cards without the discount medical plan organization's approval in writing.
 - (3) The discount medical plan organization shall be bound by and responsible for the activities of a marketer that are within the scope of the marketer's agency relationship with the organization.
- C. A discount medical plan organization shall approve in writing all advertisements, marketing materials, brochures and discount cards used by marketers to market, promote, sell or distribute the discount medical plan prior to their use.
- D. Upon request, a discount medical plan organization shall submit to the commissioner all advertising, marketing materials and brochures regarding a discount medical plan.

Section 13. Marketing Restrictions and Disclosure Requirements

- A.
 - (1) All advertisements, marketing materials, brochures, discount medical plan cards and any other communications of a discount medical plan organization provided to prospective members and members shall be truthful and not misleading in fact or in implication.
 - (2) An advertisement, any marketing material, brochure, discount medical plan card or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it is reasonably expected to create within the segment of the public to which it is directed.
- B. A discount medical plan organization shall not:
 - (1) Except as otherwise provided in this Act or as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount medical plan, use in its advertisements, marketing material, brochures and discount medical plan cards the term “insurance”;
 - (2) Except as otherwise provided in state law, describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insured product and the insurance benefits are incidental to the discount medical plan benefits;
 - (3) Use in its advertisements, marketing material, brochures and discount medical plan cards the terms “health plan,” “coverage,” “copay,” “copayments,” “deductible,” “preexisting conditions,” “guaranteed issue,” “premium,” “PPO,” “preferred provider organization,” or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is health insurance;
 - (4) Use language in its advertisements, marketing material, brochures and discount medical plan cards with respect to being [“licensed”] [“registered”] by the state insurance department in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance or has been endorsed by the state;
 - (5) Make misleading, deceptive or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card;
 - (6) Have restrictions on access to discount medical plan providers, including, except for hospital services, waiting periods and notification periods; or
 - (7) Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided under the discount medical plan, unless the discount medical plan organization has an active certificate of authority to act as a third party administrator in accordance with [insert reference to state law equivalent to the NAIC Third Party Administrator Statute].
- C. (1) Each discount medical plan organization shall make the following general disclosures:
 - (a) In writing in not less than twelve-point font;
 - (b) On the first content page of any advertisements, marketing materials or brochures made available to the public relating to a discount medical plan; and
 - (c) Along with any enrollment forms given to a prospective member:
 - (i) That the plan is a discount plan and is not insurance coverage;

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- (ii) That the range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;
- (iii) Unless the discount medical plan organization has an active certificate of authority to act as a third party administrator as described in Subsection B(7), that the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;

Drafting Note: The introductory language in Item (iii) above is intended to clarify that if a discount medical plan organization is a third party administrator, as described in Subsection B(7), then it does not have to provide this general disclosure to plan members. If the discount medical plan organization is not a third party administrator, then it must provide the general disclosure in Item (iii).

- (iv) That the plan member is obligated to pay for all medical or ancillary services, but will receive a discount from those providers that have contracted with the discount medical plan organization; and
 - (v) The toll-free telephone number and Internet website address for the [licensed] [registered] discount medical plan organization for prospective members and members to obtain additional information about and assistance on the discount medical plan and up-to-date lists of providers participating in the discount medical plan.
- (2) If the initial contact with a prospective member is by telephone, the disclosures required under Paragraph (1) shall be made orally and included in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.
- D. (1) In addition to the general disclosures required under Subsection C, each discount medical plan organization shall provide to:
- (a) Each prospective member, at the time of enrollment, information that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan; and
 - (b) Each new member a written document that contains the terms and conditions of the discount medical plan.
- (2) The written document required under Paragraph (1)(b) shall be clear and include information on:
- (a) The name of the member;
 - (b) The benefits to be provided under the discount medical plan;
 - (c) Any processing fees and periodic charges associated with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;
 - (d) The mode of payment of any processing fees and periodic charges, such as monthly, quarterly, etc., and procedures for changing the mode of payment;
 - (e) Any limitations, exclusions or exceptions regarding the receipt of discount medical plan benefits;
 - (f) Any waiting periods for certain medical or ancillary services under the discount medical plan;

- (g) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf;
- (h) Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;
- (i) Renewal, termination and cancellation terms and conditions;
- (j) Procedures for adding new members to a family discount medical plan, if applicable;
- (k) Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact his or her local state insurance department; and
- (l) The name and mailing address of the [licensed] [registered] discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices and file complaints.

Section 14. Notice of Change in Name or Address

Each discount medical plan organization shall provide the commissioner at least thirty (30) day's advance notice of any change in the discount medical plan organization's name, address, principal business address or mailing address or Internet website address.

Section 15. Annual Reports

- A. If the information required in Subsection B is not provided at the time of renewal of a [license] [certificate of registration] under Section 5 of this Act, a discount medical plan organization shall file an annual report with the commissioner in the form prescribed by the commissioner, within three (3) months after the end of each fiscal year.
- B. The report shall include:

Drafting Note: Paragraph (1) has two options. Option 1 requires a discount medical plan organization to submit audited financial statements as part of the annual report in order for the commissioner to determine whether the organization is in compliance with the minimum capital requirements required under Section 6 of this Act. Option 2 requires a discount medical plan organization to submit a certification from one of its officers verifying that the discount medical plan organization is in compliance with the minimum capital requirements required under Section 6 of this Act. States should include Paragraph (1) only if they require a discount medical plan organizations to have a minimum net worth under Section 6 of this Act as a condition of licensure.

Option 1.

- (1) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement and statement of changes in cash flow for the preceding year, except that, subject to the approval of the commissioner, an organization that is an affiliate of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity may submit the audited financial statement of the parent entity and a written guaranty that the minimum capital requirements required under Section 6 of this Act will be met by the parent entity instead of the audited financial statement of the organization;

Option 2.

- (1) A certification verified by at least one principal officer of the discount medical plan organization that the organization is in compliance with the minimum capital requirements required under Section 6 of this Act;

Drafting Note: States should adopt Paragraphs (2), (3) and (4) below regardless of which option a state chooses to adopt for Paragraph (1) above.

- (2) If different from the initial application for a [license] [certificate of registration] or at the time of renewal of a [license] [certificate of registration] or the last annual report, as appropriate, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with these persons and the discount medical plan organization, including any possible conflicts of interest;
 - (3) The number of discount medical plan members in the state; and
 - (4) Any other information relating to the performance of the discount medical plan organization that may be required by the commissioner.
- C. Any discount medical plan organization that fails to file an annual report in the form and within the time required by this section shall:
- (1) Forfeit:
 - (a) Up to \$500 each day for the first ten (10) days during which the violation continues; and
 - (b) Up to \$1,000 each day after the first ten (10) days during which the violation continues; and
 - (2) Upon notice by the commissioner, lose its authority to enroll new members or to do business in this state while the violation continues.

Section 16. Discount Prescription Drug Plan Organizations [Optional]

Drafting Note: This section is optional for those states that want to include discount prescription drug plan organizations, as that term is defined in Section 3 of this Act, within the scope of this Act.

- A. Each discount prescription drug plan organization shall designate and provide the commissioner with the name, address and telephone number of a discount prescription drug plan compliance officer responsible for ensuring compliance with the provisions of this section and this Act that are applicable to discount prescription drug plans and discount prescription drug plan organizations.
- B. In addition to Subsection A, a discount prescription drug plan organization shall comply with Sections 9, 10, 11, 12 and 13 of this Act and shall report any of the information described in Section 15 of this Act in the form and manner as the commissioner may require. A discount prescription drug plan organization also is subject to Sections 17 and 18 of this Act.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in this section, should revise Sections 17 and 18 of this Act, as appropriate, to include discount prescription drug plan organizations.

Section 17. Penalties

- A. In addition to the penalties and other enforcement provisions of this Act, any person who willfully violates this Act is subject to civil penalties of up to \$[insert amount] per violation.
- B. A person that willfully operates as or aids and abets another operating as a discount medical plan organization in violation of Section 5A of this Act commits insurance fraud and shall be subject to [insert classifications for misdemeanor and felony penalties in the state insurance code for insurance fraud], as if the [unlicensed] [unregistered] discount medical plan organization were an unauthorized insurer, and the fees, dues, charges or other consideration collected from the members by the [unlicensed] [unregistered] discount medical plan organization or marketer were insurance premium.

- C. A person that collects fees for purported membership in a discount medical plan, but purposefully fails to provide the promised benefits commits a theft and upon conviction is subject to [insert classifications for misdemeanor and felony penalties that match provisions in the state’s criminal code for theft offenses]. In addition, upon conviction, the person shall be ordered to pay restitution to persons aggrieved by the violation of this Act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

Section 18. Injunctions

- A. (1) In addition to the penalties and other enforcement provisions of this Act, the commissioner may seek both temporary and permanent injunctive relief when:
- (a) A discount medical plan is being operated by a person or entity that is not [licensed] [registered] pursuant to this Act; or
 - (b) Any person, entity or discount medical plan organization has engaged in any activity prohibited by this Act or any regulation adopted pursuant to this Act.
- (2) The venue for any proceeding brought pursuant to this section shall be in the circuit court of [insert appropriate jurisdiction].
- B. The commissioner’s authority to seek injunctive relief is not conditioned on having conducted any proceeding pursuant to the provisions of the [insert reference to state Administrative Procedure Act].

Section 19. Regulations

The commissioner may adopt regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 20. Severability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 21. Effective Date

This Act shall be effective [insert date]. A person doing business in [or from] this state as a discount medical plan organization on or before the effective date of this Act shall have six (6) months following [insert date that the Act is effective] to come into compliance with the requirements of this Act.

Drafting Note: Those states that decide to include discount prescription drug plan organizations within the scope of this Act, as provided in Section 16 of this Act, may want to include a reference to discount prescription drug plan organizations in this section.

Chronological Summary of Actions (All references are to NAIC Proceedings)

2006 Proc. 3rd Quarter 32, 35-67, 277-298 (adopted by Plenary).

2006 Proc. 3rd Quarter (adopted by Parent Committee).

2006 Proc. 2nd Quarter (adopted by Working Group).