



# House of Representatives

General Assembly

**File No. 254**

*January Session, 2005*

Substitute House Bill No. 6619

*House of Representatives, April 11, 2005*

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## ***AN ACT CONCERNING DISCOUNT HEALTH PLANS.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective July 1, 2005*) (a) As used in this section  
2 and section 2 of this act:

3 (1) "Affiliate" means a person that directly or indirectly through one  
4 or more intermediaries, controls, or is controlled by, or is under  
5 common control with, a health insurer, health care center, hospital  
6 service corporation, medical service corporation or fraternal benefit  
7 society licensed in this state;

8 (2) "Consumer" means: (A) A person to whom a discount health  
9 plan is marketed or advertised, or (B) a member, as defined in this  
10 subsection;

11 (3) "Discount health plan" means a business arrangement or contract  
12 in which a person, in exchange for payment, provides access for its

13 members to providers of health care services and the right to receive  
14 health care services from those providers at a purported discount.  
15 "Discount health plan" does not include a product that is otherwise  
16 subject to regulation or approval under title 38a of the general statutes;

17 (4) "Discount health plan organization" means a person that offers,  
18 in return for a payment of any kind, a discount health plan to residents  
19 of this state. "Discount health plan organization" does not include a  
20 health insurer, health care center, hospital service corporation, medical  
21 service corporation or fraternal benefit society licensed in this state or  
22 any affiliate of such health insurer, health care center, hospital service  
23 corporation, medical service corporation or fraternal benefit society;

24 (5) "Health care services" means any care, service or treatment of an  
25 illness or dysfunction of, or injury to, the human body. "Health care  
26 services" includes physician care, inpatient care, hospital surgical  
27 services, emergency medical services, ambulance services, dental care  
28 services, vision care services, mental health services, substance abuse  
29 services, chiropractic services, podiatric services, laboratory test  
30 services and the provision of medical equipment or supplies. "Health  
31 care services" does not include pharmaceutical supplies or  
32 prescriptions;

33 (6) "Member" means an individual who pays for the right to receive  
34 the purported benefits of a discount health plan; and

35 (7) "Person" means a person, as defined in section 38a-1 of the  
36 general statutes.

37 (b) No person may market, advertise or sell to a resident of this state  
38 a discount health plan or any plan material that: (1) Fails to provide to  
39 the consumer a clear and conspicuous disclosure that the discount  
40 health plan is not insurance and that the plan only provides for  
41 discounted health care services from participating providers within the  
42 plan; (2) uses in its advertisements, marketing materials, brochures or  
43 discount cards the term "insurance", "health plan", "coverage", "copay",  
44 "copayments", "preexisting conditions", "guaranteed issue",

45 "premium", "enrollment", "PPO", "preferred provider organization" or  
46 any other term that could reasonably mislead a person into believing  
47 the discount health plan is insurance; (3) fails to provide the name,  
48 address and telephone number of the administrator of the discount  
49 health plan; (4) fails to make available to the consumer through a toll-  
50 free telephone number, upon request of the consumer, a complete and  
51 accurate list of the participating providers within the plan in the  
52 consumer's local area and a list of the services for which the discounts  
53 are applicable; (5) fails to make a printed copy of such list available to  
54 the consumer upon request commencing with the time the plan is  
55 purchased or fails to update the list at least once every six months; (6)  
56 fails to use plain language to describe the discounts or access to  
57 discounts offered and such failure results in representations of the  
58 discounts that are misleading, deceptive or fraudulent; (7) fails to  
59 provide the consumer notice of the right to cancel such discount health  
60 plan; (8) offers discounted health services or products that are not  
61 authorized by a contract with each provider listed in conjunction with  
62 the discount health plan; (9) fails to allow a consumer to cancel a  
63 health discount plan not later than thirty days after purchase; or (10)  
64 fails to guarantee a refund of all membership fees paid to the discount  
65 health plan by the consumer not later than thirty days after timely  
66 notification of cancellation of the plan is given to the discount health  
67 plan organization.

68 (c) Any person who operates as or aids and abets another operating  
69 as a discount health plan organization in violation of this section shall  
70 be fined not more than twenty thousand dollars.

71 (d) Any person who collects fees for purported membership in a  
72 discount health plan but fails to provide the promised benefits shall be  
73 subject to the penalties for larceny under sections 53a-122 to 53a-125b,  
74 inclusive, of the general statutes, depending on the amount involved.

75 Sec. 2. (NEW) (*Effective July 1, 2005*) (a) Before doing business in this  
76 state as a discount health plan organization, an entity shall:

77 (1) Be a corporation, incorporated under the laws of this state or, if a

78 foreign corporation, authorized to transact business in this state; and

79 (2) Obtain a license as a discount health plan organization from the  
80 Insurance Commissioner in accordance with this section. The entity  
81 shall file an application for a license to operate as a discount health  
82 plan organization with the commissioner on such form as the  
83 commissioner prescribes. Such application shall be sworn to by an  
84 officer or authorized representative of the applicant, under penalty of  
85 false statement, and be accompanied by (A) a copy of the applicant's  
86 articles of incorporation, including all amendments; (B) a copy of the  
87 applicant's bylaws; (C) a list of the names, addresses, official positions  
88 and biographical information of the discount health plan organization  
89 and the individuals who are responsible for conducting the applicant's  
90 affairs, including, but not limited to, all members of the board of  
91 directors, board of trustees, executive committee, or other governing  
92 board or committee, the officers, contracted management company  
93 personnel, and any person or entity owning or having the right to  
94 acquire ten per cent or more of the voting securities of the applicant,  
95 which listing shall fully disclose the extent and nature of any contracts  
96 or arrangements between any individual who is responsible for  
97 conducting the applicant's affairs, including any possible conflicts of  
98 interest; (D) for each individual listed in subparagraph (C) of this  
99 subdivision as being responsible for conducting the applicant's affairs,  
100 a complete biographical statement, on forms prescribed by the  
101 commissioner, an independent investigation report containing  
102 information prescribed by the commissioner, and a complete set of  
103 fingerprints; (E) a statement generally describing the applicant, its  
104 personnel and the health services or other services to be offered; (F) a  
105 copy of the form of all contracts made or to be made between the  
106 applicant and any providers or provider networks regarding the  
107 provision of health services to members; (G) a copy of the form of any  
108 contract made or to be made between the applicant and any person  
109 listed in subparagraph (C) of this subdivision; (H) a copy of the form  
110 of any contract made or to be made between the applicant and any  
111 person, corporation, partnership or other entity for the performance on  
112 the applicant's behalf of any function, including, but not limited to,

113 marketing, administration, enrollment, investment management and  
114 subcontracting for the provision of health services to members; (I) a  
115 copy of the applicant's most recent financial statements audited by an  
116 independent certified public accountant; (J) a description of the  
117 proposed method of marketing; (K) a description of the subscriber  
118 complaint procedures to be established and maintained; (L) the fee for  
119 a discount health plan organization license set forth in section 38a-11  
120 of the general statutes, as amended by this act; and (M) such other  
121 information as the commissioner may require to make the  
122 determinations required by this section. For purposes of this  
123 subdivision, a "contract to be made" shall be determined based on the  
124 information known to the applicant on the date the information is filed  
125 with the commissioner.

126 (b) If the commissioner finds that the applicant is in compliance  
127 with the requirements of this section the commissioner shall issue the  
128 applicant a license as a discount health plan organization which shall  
129 expire one year after the date of issue. The commissioner shall renew  
130 the license if the commissioner finds that the licensee is in compliance  
131 with the requirements of this section and the licensee has paid the  
132 renewal fee set forth in section 38a-11 of the general statutes, as  
133 amended by this act.

134 (c) Prior to applying for a license from the commissioner, a discount  
135 health plan organization shall establish an Internet website that  
136 contains the information described in subsection (t) of this section.

137 (d) Any license or renewal fee received pursuant to this section shall  
138 be deposited in the Insurance Fund established in section 38a-52a of  
139 the general statutes.

140 (e) Nothing in this section shall require a provider who provides  
141 discounts to the provider's own patients to obtain or maintain a license  
142 as a discount health plan organization.

143 (f) Each provider who offers health services to members under a  
144 discount health plan shall provide such services pursuant to a written

145 agreement. The agreement may be entered into directly by the  
146 provider or by a provider network to which the provider belongs.

147 (g) A provider agreement shall include: (1) A list of the services and  
148 products to be provided at a discount; (2) the amount of the discounts  
149 or, alternatively, a fee schedule that reflects the provider's discounted  
150 rates; and (3) a requirement that the provider will not charge members  
151 more than the discounted rates.

152 (h) A provider agreement between a discount health plan  
153 organization and a provider network shall require that the provider  
154 network have written agreements with its providers that: (1) Contain  
155 the terms set forth in subsection (g) of this section; (2) authorize the  
156 provider network to contract with the discount health plan  
157 organization on behalf of the provider; and (3) require the network to  
158 maintain an up-to-date list of its contracted providers and to provide  
159 that list on a monthly basis to the discount health plan organization.  
160 No discount health plan organization may enter into or renew a  
161 contractual relationship with a provider network that is not licensed in  
162 accordance with section 38a-479aa of the general statutes.

163 (i) The discount health plan organization shall maintain a copy of  
164 each active provider agreement.

165 (j) Each discount health plan organization shall file an annual report  
166 with the commissioner not later than three months after the end of the  
167 fiscal year. Such annual report shall be filed on such forms as the  
168 commissioner prescribes and shall include: (1) Audited financial  
169 statements prepared in accordance with generally accepted accounting  
170 principles certified by an independent certified public accountant,  
171 including the organization's balance sheet, income statement and a  
172 statement of changes in cash flow for the preceding year; (2) a list of  
173 the names and residence addresses of all persons responsible for the  
174 conduct of the organization's affairs and a disclosure of the extent and  
175 nature of any contracts or arrangements between such persons and the  
176 discount health plan organization, including any possible conflicts of  
177 interest; (3) the number of members served by the discount health plan

178 organization; and (4) such other information relating to the  
179 performance of the discount health plan organization as is required by  
180 the commissioner.

181 (k) The commissioner may assess a discount health plan  
182 organization that fails to file an annual report in accordance with this  
183 section a fine of not more than one thousand dollars for each day of  
184 violation for the first ten days of violation and not more than two  
185 thousand dollars for each day thereafter, and the commissioner may  
186 suspend the organization's authority to enroll new members or to do  
187 business in this state while such default continues. The commissioner  
188 shall deposit all moneys collected under this subsection in the  
189 Insurance Fund established in section 38a-52a of the general statutes.  
190 The commissioner may not collect more than one hundred thousand  
191 dollars for any one annual report.

192 (l) Each discount health plan organization shall at all times maintain  
193 a net worth of at least two hundred fifty thousand dollars.

194 (m) The commissioner may not issue or renew a license under this  
195 section unless the discount health plan organization has a net worth of  
196 at least two hundred fifty thousand dollars.

197 (n) The commissioner may suspend the authority of a discount  
198 health plan organization to enroll new members, revoke any license  
199 issued to a discount health plan organization, refuse to renew a license  
200 of a discount health plan organization or order compliance if the  
201 commissioner finds that any of the following conditions exist:

202 (1) The organization is not operating in compliance with this section  
203 or section 1 of this act;

204 (2) The organization does not have the minimum net worth required  
205 by this section;

206 (3) The organization has advertised, sold or attempted to sell its  
207 services in such a manner as to misrepresent its services or capacity for  
208 service or has engaged in deceptive, misleading or unfair practices

209 with respect to advertising or sales;

210 (4) The organization is not fulfilling its obligations as a discount  
211 health plan organization; or

212 (5) The continued operation of the discount health plan organization  
213 would be hazardous to its members.

214 (o) If the commissioner has reasonable cause to believe that grounds  
215 for the suspension, nonrenewal or revocation of a license exist, the  
216 commissioner shall notify the discount health plan organization in  
217 writing specifically stating the grounds for suspension, nonrenewal or  
218 revocation.

219 (p) When the license of a discount health plan organization is  
220 surrendered, nonrenewed or revoked, the organization shall,  
221 immediately following the effective date of the order, wind up and  
222 settle the affairs transacted under the license. The organization may  
223 not engage in any further advertising, solicitation, collection of fees or  
224 renewal of contracts.

225 (q) The commissioner shall, in any order suspending the authority  
226 of a discount health plan organization to enroll new members, specify  
227 the period during which the suspension is to be in effect and the  
228 conditions, if any, which must be met by the discount health plan  
229 organization prior to reinstatement of its license to enroll new  
230 members. The commissioner may rescind or modify the order of  
231 suspension prior to the expiration of the suspension period.

232 (r) The commissioner may not reinstate a license: (1) Unless  
233 reinstatement is requested by the discount health plan organization,  
234 and (2) if the commissioner finds that the circumstances which led to  
235 the suspension still exist or are likely to recur.

236 (s) Each discount health plan organization shall provide the  
237 commissioner at least thirty days advance written notice of any change  
238 in the discount health plan organization's name, address, principal  
239 business address or mailing address.

240 (t) Each discount health plan organization shall maintain an up-to-  
241 date list of the names and addresses of the providers with which it has  
242 contracted on an Internet website, the address of which shall be  
243 prominently displayed on all its advertisements, marketing materials,  
244 brochures and discount cards. The list shall include providers with  
245 whom the discount health plan organization has contracted directly as  
246 well as providers who will provide services to the organization's  
247 members as part of a provider network with which the discount health  
248 plan organization has contracted.

249 (u) When a discount health plan organization or other person sells a  
250 discount health plan with any other product, the fees for each  
251 individual product shall be provided, in writing, to the member and  
252 itemized.

253 (v) The commissioner may adopt regulations, in accordance with  
254 chapter 54 of the general statutes, to implement the provisions of this  
255 section.

256 (w) Except as provided in subsection (k) of this section, any person  
257 who violates any provision of this section shall be fined not more than  
258 two thousand dollars.

259 Sec. 3. Subsection (a) of section 38a-11 of the general statutes is  
260 repealed and the following is substituted in lieu thereof (*Effective July*  
261 *1, 2005*):

262 (a) The commissioner shall demand and receive the following fees:  
263 (1) For the annual fee for each license issued to a domestic insurance  
264 company, one hundred dollars; (2) for receiving and filing annual  
265 reports of domestic insurance companies, twenty-five dollars; (3) for  
266 filing all documents prerequisite to the issuance of a license to an  
267 insurance company, one hundred seventy-five dollars, except that the  
268 fee for such filings by any health care center, as defined in section 38a-  
269 175, shall be one thousand one hundred dollars; (4) for filing any  
270 additional paper required by law, fifteen dollars; (5) for each certificate  
271 of valuation, organization, reciprocity or compliance, twenty dollars;

272 (6) for each certified copy of a license to a company, twenty dollars; (7)  
273 for each certified copy of a report or certificate of condition of a  
274 company to be filed in any other state, twenty dollars; (8) for  
275 amending a certificate of authority, one hundred dollars; (9) for each  
276 license issued to a rating organization, one hundred dollars. In  
277 addition, insurance companies shall pay any fees imposed under  
278 section 12-211; (10) a filing fee of twenty-five dollars for each initial  
279 application for a license made pursuant to section 38a-769; (11) with  
280 respect to insurance agents' appointments: (A) A filing fee of twenty-  
281 five dollars for each request for any agent appointment; (B) a fee of  
282 forty dollars for each appointment issued to an agent of a domestic  
283 insurance company or for each appointment continued; and (C) a fee  
284 of twenty dollars for each appointment issued to an agent of any other  
285 insurance company or for each appointment continued, except that no  
286 fee shall be payable for an appointment issued to an agent of an  
287 insurance company domiciled in a state or foreign country which does  
288 not require any fee for an appointment issued to an agent of a  
289 Connecticut insurance company; (12) with respect to insurance  
290 producers: (A) An examination fee of seven dollars for each  
291 examination taken, except when a testing service is used, the testing  
292 service shall pay a fee of seven dollars to the commissioner for each  
293 examination taken by an applicant; (B) a fee of forty dollars for each  
294 license issued; and (C) a fee of forty dollars for each license renewed;  
295 (13) with respect to public adjusters: (A) An examination fee of seven  
296 dollars for each examination taken, except when a testing service is  
297 used, the testing service shall pay a fee of seven dollars to the  
298 commissioner for each examination taken by an applicant; and (B) a fee  
299 of one hundred twenty-five dollars for each license issued or renewed;  
300 (14) with respect to casualty adjusters: (A) An examination fee of ten  
301 dollars for each examination taken, except when a testing service is  
302 used, the testing service shall pay a fee of ten dollars to the  
303 commissioner for each examination taken by an applicant; (B) a fee of  
304 forty dollars for each license issued or renewed; and (C) the expense of  
305 any examination administered outside the state shall be the  
306 responsibility of the entity making the request and such entity shall

307 pay to the commissioner one hundred dollars for such examination  
308 and the actual traveling expenses of the examination administrator to  
309 administer such examination; (15) with respect to motor vehicle  
310 physical damage appraisers: (A) An examination fee of forty dollars  
311 for each examination taken, except when a testing service is used, the  
312 testing service shall pay a fee of forty dollars to the commissioner for  
313 each examination taken by an applicant; (B) a fee of forty dollars for  
314 each license issued or renewed; and (C) the expense of any  
315 examination administered outside the state shall be the responsibility  
316 of the entity making the request and such entity shall pay to the  
317 commissioner one hundred dollars for such examination and the  
318 actual traveling expenses of the examination administrator to  
319 administer such examination; (16) with respect to certified insurance  
320 consultants: (A) An examination fee of thirteen dollars for each  
321 examination taken, except when a testing service is used, the testing  
322 service shall pay a fee of thirteen dollars to the commissioner for each  
323 examination taken by an applicant; (B) a fee of two hundred dollars for  
324 each license issued; and (C) a fee of one hundred twenty-five dollars  
325 for each license renewed; (17) with respect to surplus lines brokers: (A)  
326 An examination fee of ten dollars for each examination taken, except  
327 when a testing service is used, the testing service shall pay a fee of ten  
328 dollars to the commissioner for each examination taken by an  
329 applicant; and (B) a fee of five hundred dollars for each license issued  
330 or renewed; (18) with respect to fraternal agents, a fee of forty dollars  
331 for each license issued or renewed; (19) a fee of thirteen dollars for  
332 each license certificate requested, whether or not a license has been  
333 issued; (20) with respect to domestic and foreign benefit societies shall  
334 pay: (A) For service of process, twenty-five dollars for each person or  
335 insurer to be served; (B) for filing a certified copy of its charter or  
336 articles of association, five dollars; (C) for filing the annual report, ten  
337 dollars; and (D) for filing any additional paper required by law, three  
338 dollars; (21) with respect to foreign benefit societies: (A) For each  
339 certificate of organization or compliance, four dollars; (B) for each  
340 certified copy of permit, two dollars; and (C) for each copy of a report  
341 or certificate of condition of a society to be filed in any other state, four

342 dollars; (22) with respect to reinsurance intermediaries: A fee of five  
 343 hundred dollars for each license issued or renewed; (23) with respect  
 344 to viatical settlement providers: (A) A filing fee of thirteen dollars for  
 345 each initial application for a license made pursuant to section 38a-465a;  
 346 and (B) a fee of twenty dollars for each license issued or renewed; (24)  
 347 with respect to viatical settlement brokers: (A) A filing fee of thirteen  
 348 dollars for each initial application for a license made pursuant to  
 349 section 38a-465a; and (B) a fee of twenty dollars for each license issued  
 350 or renewed; (25) with respect to viatical settlement investment agents:  
 351 (A) A filing fee of thirteen dollars for each initial application for a  
 352 license made pursuant to section 38a-465a; and (B) a fee of twenty  
 353 dollars for each license issued or renewed; (26) with respect to  
 354 preferred provider networks, a fee of two thousand five hundred  
 355 dollars for each license issued or renewed; (27) with respect to rental  
 356 companies, as defined in section 38a-799, a fee of forty dollars for each  
 357 permit issued or renewed; (28) with respect to discount health plan  
 358 organizations licensed under section 2 of this act, a fee of five thousand  
 359 dollars for each license issued or renewed; and [(28)] (29) with respect  
 360 to each duplicate license issued a fee of twenty-five dollars for each  
 361 license issued.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2005</i>	New section
Sec. 2	<i>July 1, 2005</i>	New section
Sec. 3	<i>July 1, 2005</i>	38a-11(a)

**INS**            *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

## **OFA Fiscal Note**

### **State Impact:**

<b>Agency Affected</b>	<b>Fund-Effect</b>	<b>FY 06 \$</b>	<b>FY 07 \$</b>
Insurance Dept.	IF - Revenue Gain	Minimal	Minimal
Judicial Dept.	GF - Revenue Gain	Minimal	Minimal
Judicial Dept. (Probation); Correction, Dept.	GF - Cost	Potential	Potential
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	Potential	Potential

Note: IF=Insurance Fund; GF=General Fund

**Municipal Impact:** None

### **Explanation**

The bill requires discount health plan organizations to be incorporated in the state and to obtain a license to operate from the Insurance Commissioner. The bill also establishes fines and penalties for marketing a discount health plan that does not meet certain requirements.

### **License Requirements**

Under the bill, the Insurance Commissioner may issue and annually renew a license if the organization meets certain requirements and pays a \$5,000 annual renewal fee. License fees collected are deposited into the Insurance Fund. This will result in a minimal revenue gain to the state.

### **Fines and Penalties**

Under the bill, the Insurance Commissioner may levy, collect, and deposit into the Insurance Fund certain fines for discount health plan organization law violations. For example, any person who operates as, or aids and abets another operating as, a discount health plan

organization shall be fined up to twenty thousand dollars. This could result in a minimal revenue gain to the state.

It also specifies that any person who collects fees for purported membership in such a plan but fails to provide the promised benefits shall be subject to the criminal penalties for larceny according to the dollar value involved. To the extent that these changes increase the likelihood that offenders would be prosecuted or receive harsher penalties, a potential revenue gain from criminal fines and potential cost for incarceration and/or probation supervision in the community exist. It is anticipated that relatively few fines would be imposed on an annual basis, and, consequently, any revenue gain under the bill is expected to be minimal.

On average, it costs the state \$2,150 to supervise an offender on probation in the community as compared to \$35,040 to incarcerate the offender (note that both figures include fringe benefits).<sup>1</sup>

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<sup>1</sup> The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The estimated fringe benefit reimbursement rate as a percentage of payroll is 53.91%, effective July 1, 2004. However, first year fringe benefit costs for new positions do not include pension costs lowering the rate to 22.65%. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System.

**OLR Bill Analysis**

sHB 6619

**AN ACT CONCERNING DISCOUNT HEALTH PLANS**

**SUMMARY:**

This bill requires a discount health plan organization to be incorporated or authorized to transact business in this state and annually licensed by the insurance commissioner for a \$5,000 fee. The organization must (1) have written provider agreements that include the contracted services and discounted fees, (2) establish an Internet web site that lists participating providers, (3) file an annual report with the commissioner, and (4) maintain a net worth of at least \$250,000.

The bill prohibits marketing, advertising, or selling a discount health plan or using plan material that does not meet certain requirements. A plan and plan material must (1) include a consumer disclosure that the plan is not insurance but only provides for discounted health services from participating providers and (2) allow a consumer to cancel the plan within 30 days of purchase for a membership fee refund, among other things. They cannot use insurance-related terms.

The bill establishes fines and penalties for violations and authorizes the commissioner to adopt implementing regulations. A provider who gives discounts to his own patients is exempt from the licensing requirement.

EFFECTIVE DATE: July 1, 2005

**DEFINITIONS**

A "discount health plan" is an arrangement allowing providers to give discounted health care services to members for a fee. A "discounted health plan organization" is a person who offers discount health plans for a fee. It excludes a health insurer, HMO, hospital or service corporation, or fraternal benefit society, or an affiliate of any such entity.

**LICENSE REQUIREMENTS**

A discount health plan organization must file a completed license application with the insurance commissioner on a form she prescribes and swear to it under penalty of false statement. It must include the applicant's articles of incorporation and bylaws and the names, addresses, official positions, and biographical information of (1) the discount health plan organization and the individuals responsible for conducting its affairs and (2) any person or entity owning or having the right to acquire 10% or more of the applicant's voting securities. It must fully disclose any arrangements or interest conflicts between these individuals and for each individual, provide a complete biographical statement, an independent investigation report, and a complete set of fingerprints.

The application must also include:

1. a statement describing the applicant, its personnel, and the services to be offered;
2. a copy of all contracts made or to be made between the applicant and any
  - a. person listed above;
  - b. providers or provider networks for health services; and
  - c. person, corporation, partnership or other entity delegating functions on the applicant's behalf, including marketing, administration, enrollment, investment management, and subcontracting health service delivery;
3. the applicant's most recent independent certified public accountant-audited financial statements;
4. a proposed marketing plan;
5. a description of the required subscriber complaint procedures;
6. a \$5,000 license fee; and
7. any other information the commissioner requires.

Each discount health plan organization must maintain a net worth of

at least \$250,000.

If the applicant meets all requirements, the commissioner will issue it a discount health plan organization license, which expires one year from issue. She will renew it annually if the organization remains in compliance and pays a \$5,000 renewal fee. License fees are deposited into the Insurance Fund.

## **PROVIDER AGREEMENTS**

A provider who offers health services under a discount health plan must have a written agreement with the discounted health plan organization or belong to a provider network that does.

A provider agreement must include (1) the discounted services and products; (2) the discount amounts or a fee schedule with the provider's discounted rates; and (3) a provision prohibiting the provider from charging plan members more than the discounted rates.

A provider network agreement must require that the provider network have written agreements with its providers that (1) contain the terms described above; (2) authorize it to contract with the discount health plan organization on behalf of the provider; and (3) require it to maintain an up-to-date participating providers list that is given monthly to the discount health plan organization.

A discount health plan organization must maintain a copy of each active provider agreement. It is prohibited from contracting with a provider network that is not licensed as a preferred provider network.

## **ANNUAL REPORTING**

A discount health plan organization must file an annual report with the commissioner within three months of fiscal year-end on forms the commissioner prescribes. It must include (1) audited financial statements prepared in accordance with generally accepted accounting principles and certified by an independent certified public accountant, including the organization's balance sheet, income statement, and a statement of the preceding year's cash flow changes; (2) names and residence addresses of everyone responsible for the organization's affairs and a disclosure of arrangements or interest conflicts between such persons and the organization; (3) the number of discount health

plan members; and (4) any other information the commissioner requires.

## **PLAN REQUIREMENTS**

The bill prohibits marketing, advertising, or selling a discount health plan or using plan material that does not meet certain requirements. A plan or plan material must:

1. provide a clear and conspicuous disclosure that the plan is not insurance but only provides for discounted health care services from participating providers;
2. include the plan administrator's name, address, and telephone number;
3. have a toll-free telephone number with a complete and accurate list of the local participating providers and applicable discounted services;
4. make a printed copy of such list available upon request and update it at least once every six months;
5. use plain language that does not lead to a misleading, deceptive, or fraudulent representation of the discounts; and
6. provide notice of the consumer's right to cancel the plan within 30 days of purchase for a full membership fee refund within 30 days of cancellation.

The plan or plan material can not (1) use the term "insurance," "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "enrollment," "PPO," "preferred provider organization" or any other term that could lead a person to believe the plan is insurance or (2) offer only discounted health services or products that are not authorized by a provider agreement.

Each discount health plan organization must (1) give the commissioner at least 30 days advance written notice if it changes its name or address, (2) maintain an up-to-date list of its participating providers' names and addresses on an Internet website and, (3) include its website address prominently on all plan material.

When a discount health plan organization or other person sells a discount health plan with any other product, it must give a written and itemized bill to the member.

## **FINES AND PENALTIES**

The insurance commissioner may levy, collect, and deposit into the Insurance Fund the following fines for discount health plan organization law violations:

1. up to \$1,000 for each of the first 10 days of a violation and up to \$2,000 for each day after that, up to a maximum of \$100,000, for not filing an annual report;
2. up to \$2,000 for violating any other applicable law; and
3. up to \$20,000 for aiding and abetting another in violating these laws.

Anyone who collects discount health plan membership fees but fails to provide the promised benefits is guilty of larceny. Under the penal code, larceny can be either a class A misdemeanor or a class B, C, or D felony depending on the property value at issue.

The commissioner may suspend a discount health plan organization's authority to enroll new members and revoke or refuse to renew its license if the organization is (1) not in compliance with all applicable laws; (2) not fulfilling its obligations; or (3) hazardous to its members. If she has reasonable cause to believe that grounds exist for license suspension, non-renewal, or revocation, she must give the organization written notice of those grounds.

Her order suspending an organization's authority to enroll new members must specify when the suspension is effective and the conditions that must be met before the license may be reinstated to enroll new members. She may rescind or modify the order before the suspension period ends. She may not reinstate a license if (1) the organization does not request it and (2) the circumstances that led to the suspension still exist or are likely to recur.

When a discount health plan organization's license is surrendered, not

renewed, or revoked, it must immediately wind up and settle its affairs and cannot advertise, solicit, collect fees on, or renew contracts.

## **BACKGROUND**

### ***Penalty for False Statement***

A person who intentionally makes a false statement under oath to mislead a public official, is guilty of false statement in the 2<sup>nd</sup> degree, which is a class A misdemeanor, punishable by a fine up to \$2,000, up to one year in prison, or both.

### ***Related Bills***

SB 1249 modifies the definition of “preferred provider network” (PPN) and exempts non-risk-bearing networks from many of the current PPN requirements.

SB 1144 excludes certain private clinical laboratories from the PPN definition.

sSB 929 requires each contract between an MCO or PPN and a physician to include an explanation of (1) physician payment methodology and timing and (2) the physician payment dispute resolution process. It also requires each MCO and PPN to give network physicians a payment-determining fee schedule.

## **COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 16      Nay 0