HB 1211

Department of Legislative Services

Maryland General Assembly
2016 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1211 (Delegate Kipke, *et al.*)
Health and Government Operations

Discount Vision Plans - Provider Contracts

This bill prohibits a contract between a discount medical plan organization (DMPO) and a provider of "vision care services" from (1) limiting or specifying the fee that the provider may charge for services not included in the discount vision plan (DVP) or (2) requiring the provider to participate in one DVP as a condition of participation in another DVP or a fee-for-service provider panel. A contract must (1) require that any change in required discounts, reimbursement rates, or other contract terms be made with the signed consent of the provider and (2) disclose each discount that a provider is required to accept from a DVP member for each covered service. A provider that contracts with a DMPO that offers more than one schedule of discounts may elect to reject one or more schedule. A provider contract may not contain a provision that requires a provider, as a condition of participating in a fee-for-service panel, to participate in a DVP.

The bill takes effect October 1, 2016, and applies to all provider contracts entered into or renewed in the State on or after that date.

Fiscal Summary

State Effect: The bill does not directly affect governmental operations or finances.

Local Effect: None.

Small Business Effect: Potential meaningful impact on small business vision care providers due to the protections in the bill.

Analysis

Bill Summary: "Discount vision plan" means a discount medical plan that provides vision care services to plan members. "Vision care services" means services, including medical eye care services, provided by a provider within the scope of the provider's license to practice. "Vision care services" includes the provision of vision care materials, including lenses, devices containing spectacle lenses, contact lenses, prisms, lens treatments and coatings, and orthoptic or prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or adnexa.

Current Law: "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other financial consideration, provides the right to receive discounts on specified medical services from specified providers. "Discount medical plan organization" means an entity that contracts directly or indirectly with providers or provider networks to provide medical services at a discount to plan members and determines the charge to plan members.

A discount medical or drug plan organization may not (1) use specified terms in its advertisements, marketing material, brochures, and discount cards that could reasonably mislead a person into believing the plan was health insurance; (2) have restrictions on access to plan providers, including waiting periods and notification periods; (3) pay providers any fees for medical services, pharmaceutical supplies, prescription drugs, or medical equipment and supplies, except when also serving as a third-party administrator; (4) refuse to modify the method of payment for membership on request, unless a specific method of payment is required as a term of the plan and was agreed to in writing in advance; (5) if membership is billed on a monthly basis, refuse to permit membership to terminate without financial penalty on no more than 30 calendar days' written notice; or (6) continue electronic fund transfer payments more than 30 calendar days after a written request for termination or require the member to notify more than one entity that electronic fund transfer should be terminated.

A provider contract may not contain a provision that requires a provider (1) as a condition of participation in a nonhealth maintenance organization (non-HMO) provider panel, to participate in an HMO provider panel or (2) as a condition of participation in a fee-for-service dental provider panel, to participate in a capitated dental provider panel.

A carrier may not include in a vision provider contract a provision that requires a vision provider to (1) provide health care services that are not covered services at a fee set by the carrier; (2) provide discounts on materials that are not covered benefits; or (3) as a condition of participation in a fee-for-service vision panel, participate in a capitated vision provider panel. A vision provider contract may require a vision provider, as a condition of

participating in a non-HMO vision provider panel, to participate in a Medicaid managed care organization.

Additional Information

Prior Introductions: None.

Cross File: SB 932 (Senator Klausmeier) - Finance.

Information Source(s): Maryland Insurance Administration, Department of Budget and Management, Department of Legislative Services

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