WEST VIRGINIA CODE CHAPTER 33 ARTICLE 15E

WV Legislature

§33-15E-1. Short title.

This article shall be cited as the "Discount Medical Plan Organizations and Discount Prescription Drug Plan Organizations Act."

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§33-15E-2. Purpose.

The purpose of this article is to establish standards for discount medical plan organizations and discount prescription drug plan organizations in order to better protect consumers from unfair or deceptive marketing, sales and enrollment practices and to facilitate consumer understanding of the role and function of the organizations in providing access to medical or ancillary services.

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§33-15E-3. Definitions.

For purposes of this article:

(1) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, the specified person.

(2) "Ancillary services" includes audiology, dental, vision, mental health, substance abuse, chiropractic and podiatry services.

(3) "Control" or "controlled by" or "under common control with" has the same meaning ascribed to them in subsection (d), section two, article forty-six of this chapter.

(4) "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 plan 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. "Discount medical plan" does not include any plan that does not charge a membership or other fee to use the plan's discount medical card.

(5) "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. "Discount prescription drug plan" does not include:

(A) Any 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.

(6) "Discount medical plan organization" means an entity that contracts with providers, provider networks or other discount medical plan organizations to offer access to medical or ancillary services at a discount to plan members, provides access for discount medical plan members to the services in exchange for fees, dues, charges or other consideration, and determines the charges to plan members.

(7) "Discount prescription drug plan organization" means an entity that contracts with providers, pharmacy networks or other discount prescription drug plan organizations to offer access to pharmacy services to plan members at a discount, provides access for discount prescription drug plan members to the services in exchange for fees, dues, charges or other consideration, and determines the charges to plan members.

(8) "Facility" means an institution providing medical or ancillary services or a health care

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setting, including, hospitals or other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, rehabilitation centers or diagnostic laboratories or imaging centers.

(9) "Health care professional" means a physician, pharmacist or other health care practitioner who is licensed to perform specified medical or ancillary services within the scope of his or her license.

(10) "Marketer" means a person that markets, promotes, sells or distributes a discount medical plan, including any 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.

(11) "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, and includes, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services and medical equipment and supplies. "Medical services" does not include pharmacy or ancillary services.

(12) "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, Pub. L. 108-173 §101 et seq.

(13) "Member" means any person 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.

(14) "Patient access program" means a voluntary program sponsored by one or more 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.

(15) "Person" means an individual, a corporation, a partnership, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

(16) "Pharmacy services" includes pharmaceutical supplies and prescription drugs.

(17) "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.

(18) "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.

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§33-15E-4. Licensing requirements.

(a) A person is required to obtain a license prior to doing business in this state as a discount medical plan organization.

(b) The commissioner shall propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code, as well as emergency rules in accordance with section fifteen of said article, setting forth the licensing requirements. These rules shall include, at a minimum:

(1) All necessary forms and other information considered necessary and required by the commissioner for processing the license application;

(2) Applicable fees;

(3) Reciprocity requirements;

(4) Time frames for the application and approval process;

(5) Conditions of approval of the license application or denial of the license;

(6) Renewal process;

(7) Notice requirements; and

(8) Any other provisions considered necessary by the commissioner to effectuate the provisions of this article.

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§33-15E-5. Minimum capital requirements.

(a) Before the commissioner issues a license to any person required to obtain a license under section four of this article, the person seeking to operate a discount medical plan organization shall demonstrate that it has a positive net worth of at least $150,000.

(b) Each discount medical plan organization shall at all times maintain a positive net worth of at least $150,000.

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§33-15E-6. Surety bond requirements.

Each licensed discount medical plan organization shall maintain in force a surety bond in its own name, in an amount not less than $35,000, in favor of the commissioner for the benefit of any person who is damaged by any violation of this article. The bond shall cover any violation occurring during the time period during which the bond is in effect and shall be issued by an insurance company licensed to do business in this state. A copy of the bond or a statement identifying the depository, trustee, and account number of the surety account, and thereafter proof of annual renewal of the bond or maintenance of the surety account, shall be filed with the commissioner.

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§33-15E-7. Examinations.

The commissioner may examine 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 complaint indices, recent complaints or information from other states, or as he or she deems necessary. An examination shall be performed in accordance with the provisions of section nine, article two of this chapter, except that a discount medical plan organization that is the subject of the examination shall pay the expenses incurred in conducting the examination. Failure by the discount medical plan organization to pay the expenses is grounds for the refusal to renew, revoke or suspend a license to operate as a discount medical plan organization.

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§33-15E-8. 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) All discount medical plan certificates or other document demonstrating membership in the plan issued to persons in this state shall have a notice, prominently printed on the first page of the document or in a similarly conspicuous manner, stating that the member has the right to cancel his or her membership for any reason within thirty days of its receipt. If a member cancels his or her membership in the discount medical plan organization within the first thirty days after the date of receipt of the written document demonstrating membership, the member shall, upon return of the discount medical plan card to the discount medical plan organization, receive a reimbursement of all periodic charges and the amount of any one-time processing fee that exceeds $30. 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 e-mailed to the e-mail address of the discount medical plan organization.

(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.

(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 subdivision (1), subsection (b) of this section.

(d) A health carrier that provides a discount medical plan product that is incidental to the insured product is not subject to this section.

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§33-15E-9. Record filing and retention requirements.

(a) (1) Upon demand by the commissioner, a discount medical plan organization shall file with the commissioner a list of prospective member fees and charges associated with the discount medical plan.

(b) A copy of every form to be used by a discount medical plan organization, including the form for the written document demonstrating membership in the plan and all advertising, marketing materials and brochures, shall be retained by such organization and available for inspection by the commissioner for at least two years from the date on which such form was last used.

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§33-15E-10. 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) A written document demonstrating that the provider has agreed that it 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 subdivision (2) of this subsection;

(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 subdivision (3) of this subsection.

(5) The discount medical plan organization shall maintain a copy of each of its active provider agreements; each such organization shall also retain a copy of every inactive provider agreement for at least two years after the expiration date of each such agreement.

(b) Each discount medical plan organization shall maintain on its Internet website page a current list of the names and addresses of the providers with which it has contracted directly or through a provider network; the address of the website shall be prominently displayed on all of the discount medical plan organization's advertisements, marketing materials, brochures and discount medical plan cards.

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§33-15E-11. Marketing requirements.

(a) A discount medical plan organization may market directly or contract with other marketers for the distribution of its product.

(b) (1) A discount medical plan organization shall have a 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.

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§33-15E-12. Annual reports.

(a) If the information required in subsection (b) of this section is not provided at the time of renewal of a license under section four of this article, a discount medical plan organization shall file an annual report with the commissioner in the form prescribed by the commissioner, within three months after the end of each fiscal year.

(b) The report shall include:

(1) Audited financial statements prepared in accordance with generally accepted accounting principals 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 instead submit the audited financial statements of the parent entity and a written guaranty that the minimum capital requirements required under section five of this article will be met by the parent entity;

(2) Any changes in the list of 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 may be fined up to $500 per day for the first ten days during which the violation continues and up to $1,000 per day after the first ten days during which the violation continues. The commissioner may also suspend the organization's authority to enroll new members or to do business in this state while the violation continues.

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§33-15E-13. Discount prescription drug plan organizations.

(a) A discount prescription drug plan organization shall comply with sections eight, nine, ten and eleven of this article and shall report any of the information described in section twelve of this article in the form and manner as the commissioner may require. A discount prescription drug plan organization is also subject to sections fourteen, fifteen and sixteen of this article.

(b) 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 article that are applicable to discount prescription drug plans and discount prescription drug plan organizations.

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§33-15E-14. Administrative enforcement actions; injunctions.

(a) The commissioner may investigate the business affairs and conduct of every person applying for or holding a discount medical plan organization license and the operational affairs of a discount prescription drug plan organization to determine whether a violation of this article or any rule promulgated hereunder has occurred or is occurring.

(b) If the commissioner has cause to believe that a violation of this article or any rule promulgated hereunder has occurred or is occurring and that an enforcement action may be warranted, he or she shall notify the discount medical plan organization or discount prescription drug plan organization in writing, specifically stating the grounds for enforcement action and informing the organization that it may pursue a hearing on the matter in accordance with the provisions of section thirteen, article two of this chapter.

(c) If, after notice and hearing, a violation of this article or any legislative rule promulgated under this article is found, the Insurance Commissioner may take one or more of the following enforcement actions:

(1) Place a discount medical plan organization on probation or suspend, revoke or refuse to issue or renew the organization's license;

(2) Levy a civil penalty on the organization in an amount not exceeding $10,000 for each violation;

(3) Issue an administrative order requiring the discount medical plan organization or discount prescription drug plan organization to cease and desist from engaging in the act or practice that constitutes the violation; or

(4) Suspend the authority of the discount medical plan organization or discount prescription drug plan organization to enroll new members.

(d) In addition to the penalties and other provisions of this article, the commissioner may seek both temporary and permanent injunctive relief in the circuit court of Kanawha County when a discount medical plan is being operated by a person or entity that is not licensed pursuant to this article or any person has engaged or is engaging in any activity prohibited by this article or any rule adopted pursuant to this article.

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§33-15E-15. Criminal penalties.

(a) A person that willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (a), section four of this article is guilty of a felony and, upon conviction thereof, shall be fined not more than $20,000 for each unauthorized act or imprisoned in the state correctional facility not less than one nor more than five years, or both fined and imprisoned.

(b) No person shall collect a fee for purported membership in a discount medical plan or discount prescription drug plan and knowingly and willfully fail to provide the promised benefits of the plan.

(1) Any person who violates this subsection and in doing so collects fees totaling $1,000 or more is guilty of a felony and, upon conviction thereof, shall be fined not more than $2,500 or imprisoned in a state correctional facility not less than one nor more than ten years or, in the discretion of the court, be confined in jail for not more than one year, or both fined and imprisoned or confined.

(2) Any person who violates this subsection and in doing so collects fees totaling less than $1,000 is guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than $2,500 or confined in jail not more than one year, or both fined and confined.

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§33-15E-16. Insurance fraud unit.

The insurance fraud unit created pursuant to the provisions of section eight, article forty-one of this chapter may investigate suspected violations of this article.

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§33-15E-17. Rules.

The commissioner may propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code to carry out the provisions of this article. The commissioner may also promulgate emergency legislative rules to carry out the provisions of this article, including rules setting forth the requirements and prohibited practices with regard to the marketing of discount medical plans and discount prescription drug plans and for disclosures to members and prospective members of the plans.

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