Enrolled
House Bill 2221

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Presession filed (at the request of Governor Theodore R. Kulongoski for Department of Consumer and Business Services)

CHAPTER .....

AN ACT

Relating to discount medical plans; creating new provisions; repealing ORS 689.565; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 to 12 of this 2007 Act are added to and made a part of the Insurance Code.

SECTION 2. As used in sections 2 to 12 of this 2007 Act:

(1) "Discount medical plan" means a contract, agreement or other business arrangement between a discount medical plan organization and a plan member in which the organization, in exchange for fees, service or subscription charges, dues or other consideration, offers or purports to offer the plan member access to providers and the right to receive medical and ancillary services at a discount from providers.

(2) "Discount medical plan organization" means a person that contracts on behalf of plan members with a provider, a provider network or another discount medical plan organization for access to medical and ancillary services at a discounted rate and determines what plan members will pay as a fee, service or subscription charge, dues or other consideration for a discount medical plan.

(3) "Licensee" means a discount medical plan organization that has obtained a license from the Director of the Department of Consumer and Business Services in accordance with section 5 of this 2007 Act.

(4) "Medical and ancillary services" means, except when administered by or under contract with the State of Oregon, any care, service, treatment or product provided for any dysfunction, injury or illness of the human body including, but not limited to, physician care, inpatient care, hospital and surgical services, emergency and ambulance services, audiology services, dental care services, vision care services, mental health services, substance abuse counseling or treatment, chiropractic services, podiatric care services, laboratory services, home health care services, medical equipment and supplies or prescription drugs.

(5) "Plan member" means an individual who pays fees, service or subscription charges, dues or other consideration in exchange for the right to participate in a discount medical plan.

(6)(a) "Provider" means a person that has contracted or otherwise agreed with a discount medical plan organization to provide medical and ancillary services to plan members at a discount from the person's ordinary or customary fees or charges.

(b) "Provider" does not include:

(A) A person that, apart from any agreement or contract with a discount medical plan organization, provides medical and ancillary services at a discount or at fixed or scheduled prices to patients or customers the person serves regularly; or

(B) A person that does not charge fees, service or subscription charges, dues or other consideration in exchange for providing medical and ancillary services at a discount or at fixed or scheduled prices.

(7) "Provider network" means a person that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider that provides medical or ancillary services to plan members.

SECTION 3. (1) A person may not conduct business as or purport to conduct business as a discount medical plan organization unless the person first obtains a license to operate as a discount medical plan organization from the Director of the Department of Consumer and Business Services in accordance with section 5 of this 2007 Act.

(2) The license requirement set forth in subsection (1) of this section does not apply to an insurer that offers a discount medical plan.

SECTION 4. (1) A discount medical plan organization shall have a written contract or other written agreement with all providers or provider networks that the organization includes or purports to include in a discount medical plan, or with an entity that contracts with or enters into an agreement with a provider network on the organization's behalf.

(2) The contract or other agreement between a discount medical plan organization and a provider must include:

(a) A list of the medical and ancillary services included in the discount medical plan;

(b) The provider's discount rate or rates or a schedule that reflects the provider's fixed or discounted prices for the medical and ancillary services subject to the discount medical plan; and

(c) A provision in which the provider agrees not to charge plan members more for medical and ancillary services than the amount listed in the provider's price schedule or an amount that reflects the application of the provider's discount rate.

(3) The contract or other agreement between a discount medical plan organization and a provider network, or between an entity and a provider network when the entity contracts with or enters into an agreement with a provider network on the organization's behalf, shall require the provider network to have written agreements with providers that, in addition to meeting the requirements of subsection (2) of this section:

(a) Authorize the provider network to contract with or enter into an agreement with the discount medical plan organization or the entity on behalf of the provider; and

(b) Require the provider network to maintain an up-to-date list of the providers that are part of the provider network and to provide the updated list each month to the discount medical plan organization.

(4) A discount medical plan organization shall retain copies of the contracts or agreements and other documents described in this section at all times during which the organization operates in this state.

SECTION 5. (1) Each applicant for a license to operate as a discount medical plan organization shall apply to the Director of the Department of Consumer and Business Services in a form and manner that the director prescribes by rule. An application for a license under this section must contain all of the following:

(a) The applicant's name, fictitious name, assumed business name and any other identity the applicant uses in conducting business.

(b) The applicant's business address, mailing address, electronic mail address and the Internet address of any website the applicant maintains for public access.

(c) The applicant's federal employer identification number or Internal Revenue Service taxpayer identification number.

(d) The applicant's principal place of business inside or outside this state.

(e) The name of and contact information for a person that the applicant has designated to provide information to consumers or answer consumer questions.

(f) The name and address of the applicant's agent for the service of process, notice or demand, or a power of attorney that the applicant has executed and by which the applicant appoints the director as the applicant's agent for the service of process, notice or demand.

(g) A list of individual providers or providers included in the provider network that provide services in this state and a list of the medical and ancillary services the applicant offers or intends to offer to plan members as part of a discount medical plan or the Internet address of a website that lists the providers and services offered.

(h) A list of the persons that the applicant has authorized or intends to authorize to market a discount medical plan in this state under a name that is different from the applicant's name.

(i) The name, trade name, service mark or other means by which a consumer can identify the discount medical plan the applicant offers or intends to offer and any different name, trade name, service mark or other means the applicant uses to identify the same discount medical plan to persons other than consumers.

(j) A statement that discloses:

(A) Any criminal conviction in the five-year period before the date of application involving the applicant, a member of the board of directors or an officer of the applicant and any person owning or having the right to acquire 10 percent or more of the voting securities of the applicant; and

(B) Any pending investigation into the applicant's business activities brought by a licensing, regulatory or law enforcement authority in any jurisdiction.

(k) A statement in which the applicant agrees to submit to the personal jurisdiction of the courts of this state.

(L) A statement that discloses any instance in which another jurisdiction has denied the applicant a license or other authority to operate as a discount medical plan organization or has suspended or revoked any such license or other authority after issuance.

(m) Other information the director may require that enables the director, after reviewing all of the information submitted under this subsection, to determine whether the applicant:

(A) Is financially responsible;

(B) Has adequate experience and expertise to operate a discount medical plan organization; and

(C) Is of good character.

(2) Upon receipt of a completed application for a license to operate as a discount medical plan organization, the director may investigate the applicant as necessary to verify the information contained in the application. Except as provided in subsection (3) of this section, if the director is satisfied that the information contained in the application is accurate and complete, the director shall issue a license to the applicant.

(3) The director may deny a license to any applicant if the director finds in writing that:

(a) The applicant has provided false, misleading, incomplete or inaccurate information in the application; or

(b) The applicant is not qualified to operate as a discount medical plan organization because the applicant is not financially responsible, does not have adequate experience or expertise, or has engaged in dishonest, fraudulent or illegal practices or conduct in any business or profession.

(4) If the director denies a license under this section, the applicant may request a hearing under ORS 183.435. Upon receiving the applicant's request, the director shall grant the applicant a hearing under ORS 183.413 to 183.470.

SECTION 6. A licensee shall:

(1) Notify the Director of the Department of Consumer and Business Services immediately whenever the licensee's license or other form of authority to operate as a discount

medical plan organization in another jurisdiction is suspended, revoked or not renewed in that jurisdiction.

(2) Describe in a notice to the director any change in the name, address or contact information of the discount medical plan organization provided in the application under section 5 of this 2007 Act within 30 days after making the change.

SECTION 7. A license obtained under section 5 of this 2007 Act is effective for one year, or for a longer period if the Director of the Department of Consumer and Business Services so prescribes by rule. The director shall prescribe by rule conditions and procedures under which a licensee may renew a license that has expired.

SECTION 8. A discount medical plan organization shall establish or provide, in connection with every discount medical plan:

(1) A 30-day period in which new plan members may review the discount medical plan and decide whether to continue or to cancel the plan for any reason. The discount medical plan organization shall provide to a member who cancels a discount medical plan within the 30-day period a full and unconditional refund for any fees, service or subscription charges, dues or other consideration the member paid, except that the discount medical plan organization may retain the amount of any one-time processing fee that is less than an amount established by the Director of the Department of Consumer and Business Services by rule. The 30-day period begins on the day following the date on which the member completed any application for the plan or the day following the date on which the member paid any fees, service or subscription charges, dues or other consideration, whichever is later.

(2) A standard set of procedures by which a new plan member may obtain a refund under subsection (1) of this section.

(3) A toll-free telephone line and an Internet website. The toll-free telephone line must enable plan members to contact the discount medical plan organization with questions and requests for assistance. The website must list all providers in the organization's provider network, and the organization must provide the same information to plan members in writing upon request.

(4) Disclosures, in writing in a font not less than 12 points in size and on the first content page of advertisements, marketing materials or brochures made available to the public and relating to a discount medical plan, that:

(a) The discount medical plan is not insurance; and

(b) Plan members must pay for all medical and ancillary services, but will receive a discount from providers.

SECTION 9. (1) A person may not use or disseminate in marketing, advertising, promotional, sales or plan documents or other informational materials for discount medical plans or in communications with plan members or prospective plan members:

(a) Misleading, deceptive or false statements; or

(b) The terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting condition," "guaranteed issue," "premium," "preferred provider organization" or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance.

(2) For the purposes of subsection (1) of this section, "misleading, deceptive or false statements" includes, but is not limited to, statements that:

(a) Are misleading in fact or implication, including statements that, while containing truthful elements, conceal or omit information necessary or relevant for a consumer to make informed decisions concerning discount medical plans; or

(b) Have a capacity or tendency to mislead or deceive based on the overall impression a reasonable consumer may form after seeing or hearing the statements.

(3) A person may not represent in any marketing, advertising, promotional, sales or plan documents or other informational materials for a discount medical plan or in communi-

cations with plan members or prospective plan members that the State of Oregon reviews or approves the discount medical plan.

(4) Before a person uses an advertisement, a brochure, a discount card or promotional or marketing material for marketing, promoting, selling or distributing a discount medical plan, the discount medical plan organization shall approve the material in writing.

(5) At the request of the Director of the Department of Consumer and Business Services, a discount medical plan organization shall submit to the director an advertisement, a brochure, a discount card or promotional or marketing material used for marketing, promoting, selling or distributing a discount medical plan.

SECTION 10. The Director of the Department of Consumer and Business Services may investigate a person operating or purporting to operate as a discount medical plan organization and may require the person at any time to produce marketing, promotional and advertising materials, records, books, files or other information the person uses in conducting business as a discount medical plan organization. During an investigation, the person shall respond to the director's inquiries promptly and truthfully and in the manner or form the director requires. The person subject to an investigation under this section shall pay the expenses incurred in conducting the investigation.

SECTION 11. (1) The Director of the Department of Consumer and Business Services by order may suspend, revoke or refuse to renew a license issued under section 5 of this 2007 Act if the director finds in writing that:

(a) Any fact or condition exists that, if the fact or condition had existed at the time the licensee applied for a license to operate as a discount medical plan organization, would have been grounds for the director to deny a license to the licensee;

(b) The licensee has not complied or is not complying with the licensee's obligations under section 4, 5, 6, 8 or 10 of this 2007 Act or any rule adopted thereunder or the licensee has violated or is violating a prohibition under section 9 of this 2007 Act; or

(c) The licensee's license or other authority to operate as a discount medical plan organization in another state has been suspended or revoked or has not been renewed.

(2) A licensee subject to an order of the director suspending or revoking a license shall have an opportunity for a hearing under ORS 183.413 to 183.470.

(3) After the director issues a final order to suspend or revoke a license, the person subject to the order may not conduct further business as a discount medical plan organization in this state. Immediately after the director issues a final order suspending or revoking a license, the person subject to the order shall:

(a) Cease operations as a discount medical plan organization in this state;

(b) Cancel all pending transactions with plan members and refund any fees, service or subscription charges, dues or other consideration collected in exchange for services the person would have provided to plan members in connection with a discount medical plan after the effective date of the final order suspending or revoking the person's license; and

(c) Wind up all business conducted in connection with the person's operations as a discount medical plan organization in this state, if necessary.

SECTION 12. (1) A person, a municipal or other public corporation or, at the request of the Director of the Department of Consumer and Business Services, the Attorney General may bring an action in a circuit court of this state against a person that operates or purports to operate as a discount medical plan organization but that has not obtained a license under section 5 of this 2007 Act, to:

(a) Enjoin the person from operating or purporting to operate as a discount medical plan organization or from violating section 8 or 9 of this 2007 Act or any rule adopted thereunder; or

(b) Recover actual damages or statutory damages under this section that arise from the person's violation of section 8 or 9 of this 2007 Act or any rule adopted thereunder.

(2) A plaintiff may bring an action under this section in the county where:

(a) The plaintiff resides or conducts business; or

(b) The defendant marketed, offered for sale or sold, promoted, distributed or advertised a discount medical plan.

(3) If the court finds that the defendant has violated section 3, 8 or 9 of this 2007 Act or any rule adopted thereunder, the court shall enjoin the defendant from continuing the violation.

(4) Unless a plaintiff seeks actual or statutory damages under this section, the plaintiff need not allege or prove actual damages to bring an action for an injunction under this section.

(5) In addition to injunctive relief, the plaintiff who prevails in an action brought under this section is entitled to recover from the defendant:

(a) $100 for each discount medical plan membership sold or otherwise distributed within this state or $10,000, whichever is greater;

(b) Three times the amount of actual damages, if any, that the plaintiff sustained;

(c) Reasonable attorney fees;

(d) Costs; and

(e) Any other relief the court deems proper.

(6) A plaintiff must commence an action under this section within two years after the date on which the violation described in subsection (1) of this section occurred or within two years after the plaintiff bringing the action discovered or in the exercise of reasonable diligence should have discovered the violation. The plaintiff may have an additional 180 days after the two-year period provided in this subsection within which to commence an action if the plaintiff can prove by a preponderance of the evidence that the plaintiff failed to timely commence the action because of conduct by the defendant calculated solely to induce the plaintiff to refrain from or postpone commencement of the action.

(7) The remedies provided in this section are cumulative and are in addition to any other applicable criminal, civil or administrative penalties.

SECTION 13. ORS 689.565 is repealed.

SECTION 14. Sections 2 to 12 of this 2007 Act apply to any person conducting business as a discount medical plan organization, as defined in section 2 of this 2007 Act, on or after the operative date of this 2007 Act.

SECTION 15. Sections 1 to 12 of this 2007 Act and the repeal of ORS 689.565 by section 13 of this 2007 Act become operative on July 1, 2008.

SECTION 16. The Director of the Department of Consumer and Business Services may take any action before the operative date of sections 1 to 12 of this 2007 Act and the repeal of ORS 689.565 by section 13 of this 2007 Act that is necessary to enable the director to exercise, on and after the operative date of sections 1 to 12 of this 2007 Act and the repeal of ORS 689.565 by section 13 of this 2007 Act, all the duties, functions and powers conferred on the director by sections 1 to 12 of this 2007 Act.

SECTION 17. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.

Passed by House April 10, 2007

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Chief Clerk of House

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Speaker of House

Passed by Senate May 15, 2007

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President of Senate

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

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Governor

Filed in Office of Secretary of State:

.....M.,....., 2007

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Secretary of State