

## CHAPTER 17.

### DISCOUNT MEDICAL PLAN ORGANIZATIONS

#### **SECTION 37-17-10.** Citation of chapter.

This chapter may be cited as the “Discount Medical Plan Organization Registration Act”.

#### **SECTION 37-17-20.** Definitions.

As used in this chapter:

- (1) “Administrator” means the administrator of the South Carolina Department of Consumer Affairs.
- (2) “Discount medical plan organization” means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for customers to providers of health care services and the right to receive health care services from those providers at a discount. There can be only one discount medical plan organization for each discount program. The discount medical plan organization 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 customers.
- (3) “Health care services” means any care, service, or treatment of an illness or dysfunction of, or injury to, the human body. Health care services includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency medical services, ambulance services, dental care services, vision care services, mental health care services, substance abuse services, chiropractic services, podiatric services, laboratory test services, the provision of medical equipment or supplies, and pharmaceutical supplies or prescriptions.
- (4) “Department” means the South Carolina Department of Consumer Affairs.
- (5) “Marketer” means a corporation, partnership, or other business entity including, but not limited to, a health maintenance organization, an insurance company, or third party payor, who sells, markets, promotes, advertises, or distributes a discount medical plan or other purchasing mechanism or device that purports to offer discounts or access to discounts from the health care providers described in item (3) in this State on behalf of a discount medical plan organization.
- (6) “Representative” means an individual who is designated by a discount medical plan organization, as defined in this section, and acts or aids on behalf of the discount medical plan organization in the solicitation, negotiation, or renewal of a discount medical plan with respect to South Carolina citizens.
- (7) “Customer” means an individual who pays for the right to receive the benefits of a discount medical plan.
- (8) “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).

#### **SECTION 37-17-30.** Discount medical plan organizations; organizational, marketing and advertising requirements.

(A) It is unlawful for a discount medical plan organization to sell, market, promote, advertise, or distribute to a customer a discount medical plan or other purchasing mechanism or device that is not insurance which purports to offer discounts or access to discounts from health care providers unless:

- (1) the discount medical plan organization is organized pursuant to the laws of this State or authorized to transact business in this State;
- (2) the discount medical plan organization is registered with the department for this express purpose;
- (3) the plan or other purchasing mechanism or device expressly states in bold and prominent type, prominently placed, that the discounts are not insurance;

(4) documentation is provided to the department that the health care service providers, pharmacies, or pharmacy chains listed in conjunction with the plan or other purchasing mechanism or device are contracted to offer the discount; and

(5) the discounts or access to discounts offered, or the range of discounts or access to the range of discounts offered, are not misleading, deceptive, or fraudulent.

(B)(1) A discount medical plan organization or a marketer who sells, markets, promotes, advertises, or distributes a discount medical plan or other purchasing mechanism or device that is not insurance that purports to offer discounts or access to discounts from health care providers in this State shall designate a resident of this State as an agent for service of process and register the agent with the Secretary of State.

(2) In the absence of proper registration pursuant to subsection (B)(1), the Secretary of State is designated as an agent upon whom process may be served. Service of process on the Secretary of State may be made by delivering to and leaving with the Secretary of State, or with a person designated by him to receive service, duplicate copies of the process, notice, or demand. The Secretary of State shall forward one of the copies by registered or certified mail, return receipt requested, to the discount medical plan organization required to register pursuant to subsection (B)(1) at the last physical address known to the party service process. Refusal to sign the return receipt does not affect the validity of the service. Service is effective pursuant to this subsection as of the date shown on the return receipt or five days after its deposit in the mail, whichever is earlier. The Secretary of State may charge a fee of ten dollars for the service. This subsection does not affect the right to serve process in a manner otherwise provided by law.

(3) Discount medical plan organizations selling, distributing, advertising, marketing, or promoting discount medical plans to customers shall be registered with the department as provided by Section 37-17-40 (C). A contact with South Carolina citizens, including personal contact, telemarketing, direct mail, or Internet/electronic mail solicitation, requires registration with the department, and business must not be conducted until the registration is made with the department.

(4) Representatives of a discount medical plan organization must be authorized by the discount medical plan organization before they offer services pursuant to this chapter.

(5) A discount medical plan organization shall make available the plan and its terms to prospective customers and provide to each of its customers the range of the benefits of the plan. Prior and subsequent to the sale of the plan, on an ongoing basis, the discount medical plan organization shall make available, upon request, through a toll-free telephone number, the Internet, and in writing, a complete listing of all participating facilities in this State. The 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 must be prominently displayed on all of its advertisement, marketing material, brochures, and discount medical plan cards.

(6) Advertised discounts are those that are actually available to customers. One-time or short-time promotions may be offered only if limiting terms are as prominent as the special offer. All advertisements must contain the name and address of the company offering the service and must conform to the name on file with the department.

(C) This section does not require a provider who provides discounts to his or her own patients to obtain and maintain a license pursuant to this chapter as a discount medical plan organization.

**SECTION 37-17-40.** Registration and renewal; list of authorized representatives and marketers.

(A) A discount medical plan organization applying for an initial or renewal registration must submit:

(1) a formal application in the form and detail the administrator requires;

(2) if a corporation:

(a) articles of incorporation; and

(b) proof of existence and good standing from the Secretary of State's office;

(3) a bond in a form to be prescribed by the department in the amount of fifty thousand dollars denoting the department as beneficiary;

(4) the most recent financial statement prepared in accordance with generally accepted accounting principles and certified by two principal officers of the applicant or, if the applicant is not a corporation, other persons the administrator requires; provided that an applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may submit, in lieu of the certified financial statement of the applicant, the audited financial statement of the parent;

(5)(a) a filing fee of five hundred dollars if the list of representatives provided by the discount medical plan organization contains no more than a total of fifty representatives;

(b) a filing fee of seven hundred and fifty dollars if the list of representatives provided by the discount medical plan organization contains a total of fifty-one to one hundred representatives;

(c) a filing fee of one thousand dollars if the list of representatives provided by the discount medical plan organization contains more than one hundred representatives;

(6) a description of: (a) the offered plan, (b) advertising and solicitation brochures, (c) any cards or other purchasing mechanisms, and (d) customer enrollment materials, any of which the discount medical plan organization uses or intends to use; and

(7) other relevant material information required by the administrator.

(B) Registration is annually on a form prescribed by the department. An annual filing fee must accompany each filing and be retained by the department for purposes of administering the filings. The registration runs from February first until January thirty-first, and the annual renewal period begins January first and ends on January thirty-first. A discount medical plan organization who files its renewal on a timely basis may continue operating unless the registration is denied or revoked by the department.

(C) A discount medical plan organization shall provide annually to the department at the time of initial registration with a list of all representatives and marketers authorized to sell, market, promote, advertise, or distribute to customers a discount medical plan of the discount medical plan organization by January thirty-first of each year and the department may make inquiry on specific marketers or representatives on a case by case basis. With regard to a renewal or a subsequent registration, the discount medical plan organization shall provide annually to the department at the time of renewal or subsequent registration with a list of all representatives and marketers authorized to sell, market, promote, advertise, or distribute to customers a discount medical plan of the discount medical plan organization, whereas this list shall include any additional representatives and/or marketers since the last list provided by the discount medical plan organization to the department.

#### **SECTION 37-17-50. Representative or marketer status.**

(A) An individual may not act as a representative of a discount medical plan organization without the discount medical plan organization having registered with the department in accordance with Section 37-17-40(A). A marketer may not act on behalf of a discount medical plan organization without a discount medical plan organization having registered with the department. Registration as a representative or marketer must be made to the department in writing or electronically through a list provided by the discount medical plan organization in accordance with Section 37-17-40(C).

(B) The discount medical plan organization shall furnish information concerning the representative's identity and business address. Filings are good for one year and run from February first until January thirty-first. The annual renewal period begins January first and ends January thirty-first.

(C) Representative or marketer status may be denied or revoked if the department has multiple founded complaints against the representative or marketer following the department's investigation or if the department has unanswered or unresolved complaints against the representative or marketer. Violations of Title 37 within ten years may serve as grounds for denial or revocation of registration status.

**SECTION 37-17-52.** Information provided to applicant.

(A) A discount medical plan organization shall provide to an applicant, the time of application, information that describes the terms and conditions of the discount medical plan, including limitations or restrictions on the refund of processing fees or periodic charges associated with the discount medical plan, and to a new customer, a written document that contains the terms and conditions of the discount medical plan.

(B) The written document required pursuant to subsection (A) must be clear and include:

- (1) the name of the customer;
- (2) the benefits to be provided under the discount medical plan;
- (3) processing fees and periodic charges associated with the discount medical plan including any limitations or restrictions on the refund of processing fees and periodic charges;
- (4) the mode and timing of payment of processing fees and periodic charges and procedures for changing the mode of payment;
- (5) any limitations, exclusions, or exceptions regarding the receipt of discount medical plan benefits;
- (6) waiting periods for certain medical or ancillary services under the discount medical plan;
- (7) procedures for obtaining discounts under the discount medical plan, such as requiring customers to contact the discount medical plan organization to make an appointment with a provider on the customer's behalf;
- (8) cancellation procedures including information on the customer's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;
- (9) renewal, termination, and cancellation terms and conditions;
- (10) procedures for adding new customers to a family discount medical plan, if applicable;
- (11) procedures for filing complaints under the discount medical plan organization's complaint system; and
- (12) the name and mailing address of the registered discount medical plan organization or other entity where the customer can make inquiries about the plan, send cancellation notices and file complaints.

**SECTION 37-17-55.** Cancellation of membership; disclosures on initial contact; cancellation by customer.

(A) if the discount medical plan organization cancels a membership for any reason other than nonpayment of fees by the customer, the discount medical plan organization shall make prorated reimbursement of all periodic charges to the customer.

(B) If the initial contact with the prospective customer is by telephone, disclosures must 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 customer and disclose that:

- (1) the plan is not insurance;
- (2) 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;
- (3) unless the discount medical plan organization has an active certificate of authority to act as a third party administrator, the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;
- (4) the customer is obligated to pay for all medical or ancillary services, but receives a discount from those providers that have contracted with the discount medical plan organization; and
- (5) there is a toll-free telephone number and Internet website address for the registered discount medical plan organization for prospective customers and customers 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, and that number and website address.

(C) A discount medical plan issued for delivery in this State is returnable or cancelable, within thirty days of the date of delivery of the card or a longer period if provided in the purchase agreement, by the

customer or user for any reason, and the customer must receive a full refund of all fees, except nominal fees associated with enrollment costs, that were part of the cost of the card.

(1) A discount medical plan organization may not charge or collect a fee including a cancellation fee after a customer or user has given the organization notice of the customer's intention to return or cancel the plan.

(2) A discount medical plan organization shall ensure that each customer or user receives with the card a notice stating the terms under which the discount medical plan may be returned or cancelled. A discount medical plan returned or cancelled in accordance with this section is void from the date of purchase.

#### **SECTION 37-17-60.** Application of chapter.

This chapter does not apply to:

(1) a pharmacy holding a permit or a company that owns one or more pharmacies holding a permit issued pursuant to Title 40, Chapter 43, that offers prescription discounts only from pharmacies;

(2) a benefit or program offered by a health insurer, health care service contractor, or health maintenance organization regulated pursuant to Title 38. A health insurer, health care service contractor, or health maintenance organization regulated pursuant to Title 38 that offers a discount medical plan that is not offered in conjunction with a health insurance plan it administers shall provide the department written notice of the name under which such a discount medical plan is offered and the telephone number and mailing address at which the plan can be contacted. The notice required by this subsection shall be provided to the department within thirty days of the initial offering of new medical discount plans in this State, and within ninety days of the effective date of this chapter for existing plans;

(3) an insured benefit administered by, or under contract with, the State of South Carolina; or

(4) a patient access program voluntarily sponsored by a pharmaceutical manufacturer, or a consortium of pharmaceutical manufacturers that provides free or discounted products directly to individuals either through a discount or direct shipment.

#### **SECTION 37-17-70.** Administrative appeals.

An appeal concerning disciplinary action, a denial of an application for a new or renewal registration, a revocation or suspension of a registration, or a determination that a representative is unqualified must be made pursuant to the Administrative Procedures Act and the rules governing practice before the Administrative Law Court. A contested hearing pursuant to this chapter is before the Administrative Law Court, with notice to, and an opportunity for a hearing by, the affected discount medical plan organization, marketer, or representative.

#### **SECTION 37-17-80.** Hearings before Administrative Law Court; assessment of administrative penalties.

(A) The department may file a request for a contested case hearing with the Administrative Law Court for an order requiring a person to cease and desist or an order revoking, suspending, or vacating the certificate of authority of a person, if the Administrative Law Court finds, after a hearing that the person:

(1) has violated or failed to comply with a provision of this chapter or a regulation promulgated pursuant to the authority of this chapter;

(2) has obtained a certificate of authority through wilful misrepresentation or fraud;

(3) has engaged in a fraudulent or deceptive practice;

(4) has wilfully, orally or in writing, misrepresented the terms, benefits, privileges, and provisions of a discount medical plan issued or to be issued by it;

(5) is unable to meet obligations as determined by generally accepted accounting principles;

(6) has, after notice to the person of an alleged occurrence of any of items (1) through (5) of this section, refused without just cause to submit relevant information to the administrator with respect to its services within this State.

(B) Instead of revocation, suspension, or refusal to continue a certificate of authority for a violation or violations of items (1) through (6) of subsection (A), the administrative law judge may assess an administrative penalty of not less than one hundred nor more than ten thousand dollars for each violation. These penalties may be assessed in connection with orders to cease and desist.

**SECTION 37-17-90.** Cease and desist orders.

Upon satisfactory evidence that a discount medical plan organization has violated or failed to comply with a provision of this chapter or regulation promulgated pursuant to the authority of this chapter, the administrator may issue an order requiring the discount medical plan organization to cease and desist from engaging in the violation or may revoke or suspend the discount medical plan organization's registration.

**SECTION 37-17-100.** Request for reinstatement hearing following revocation or denial of renewal.

If a registration is revoked or renewal is denied, the affected discount medical plan organization may request a reinstatement hearing after a minimum of one year. The department may reinstate or renew the registration only if the cause of the nonrenewal or revocation has been corrected.

**SECTION 37-17-110.** Assessment of costs.

A discount medical plan organization that is found to be engaged in unlawful conduct may be assessed the reasonable costs necessary to the investigation, disciplinary proceedings, court proceedings, or other actions to enforce the provisions of this chapter.

**SECTION 37-17-120.** Promulgation of regulations.

The department may promulgate regulations necessary to effectuate the purposes of this chapter.