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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2010

A N A C T

RELATING TO INSURANCE - DISCOUNT MEDICAL PLANS

Introduced By: Senators Sheehan, Perry, Pichardo, Crowley, and Raptakis

Date Introduced: March 04, 2010

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 73

DISCOUNT MEDICAL PLAN ORGANIZATION ACT

27-73-1. Short title. -- This chapter shall be known and may be cited as the "Discount Medical Plan Organization Act."

27-73-2. Purpose. – The purpose of this chapter is to promote the public interest by establishing standards for discount medical plan organizations, protect consumers from unfair or deceptive marketing, sales or enrollment practices, and facilitate consumer understanding of the role and function of discount medical plan organizations in providing access to medical or ancillary services.

27-73-3. Definitions. – As used in this chapter: (1) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(2) "Ancillary services" includes, but is not limited to, audiology, dental, vision, mental health, substance abuse, chiropractic, and podiatry services.

(3) "Commissioner" means the health insurance commissioner.

(4) "Control" or "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of

a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by subsection 27-35-3(i) that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(5) "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges or other consideration, offers its members access 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.

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

(7) "Discount medical plan organization" means an entity that, in exchange for fees, dues, charges or other consideration, provides access for discount medical plan members to providers of medical or ancillary services and the right to receive medical or ancillary services from those providers at a discount. It 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 members.

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

(9) "Facility" includes, but is not limited to:

(i) A hospital or other licensed inpatient center;

(ii) An ambulatory surgical or treatment center;

(iii) A skilled nursing center;

(iv) A residential treatment center;

(v) A rehabilitation center; and

(vi) A diagnostic, laboratory or imaging center.

(10) "Health care professional" means a physician, pharmacist or other health care practitioner who is licensed, accredited or certified to perform specified medical or ancillary services within the scope of his or her license, accreditation, certification or other appropriate

authority and consistent with state law.

(11) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and medical service corporation, or any other entity providing a plan of health insurance, health benefits or medical or ancillary services.

(12) "Marketer" means a person or entity that markets, promotes, sells or distributes a discount medical plan, including a private label 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.

(13) "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.

(14) "Medical services" includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services and medical equipment and supplies.

(15) "Medical services" does not include pharmacy services or ancillary services.

(16) "Member" means any individual who pays fees, dues, charges or other consideration for the right to receive the benefits of a discount medical plan.

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

(18) "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.

(19) "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.

27-73-4. Applicability and scope. – (a) This chapter applies to all discount medical plan organizations doing business in or from this state.

(b) A discount medical plan organization that is a licensed health insurer or health maintenance organization or a nonprofit hospital and medical service corporation is not required to obtain a certificate of registration under section 27-73-5, except that any of its affiliates that

operate as a discount medical plan organization in this state shall obtain a certificate of registration under section 27-73-5 and comply with all other provisions of this chapter; but such health insurer, health maintenance organization or nonprofit hospital and medical service corporation is required to comply with sections 27-73-8, 27-73-9, 27-72-10, and 27-73-11 and report, in the form and manner as the commissioner may require, any of the information described in section 27-73-13 that is not otherwise already reported.

27-73-5. Registration requirements. – (a) Before doing business in or from this state as a discount medical plan organization, a person shall obtain a certificate of registration from the commissioner to operate as a discount medical plan organization.

(b) Each application for a certificate of registration to operate as a discount medical plan organization:

(1) Shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant;

(2) Shall be accompanied by a fee of two hundred fifty dollars ($250) payable to the state of Rhode Island;

(3) Shall include information on whether:

(i) A previous application for a certificate of registration, license or permit to operate as a medical discount plan has been denied, revoked, suspended or terminated for cause in any jurisdiction (including Rhode Island); and

(ii) The applicant is under investigation for or the subject of any pending action or has been found in violation of a statue or regulation in any jurisdiction (including Rhode Island) within the previous five (5) years;

(4) Shall include information, as the commissioner may require, that permits the commissioner, after reviewing all of the information submitted pursuant to this subsection, to make a determination that the applicant:

(i) Is financially responsible;

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

(iii) Is of good character.

(c) After the receipt of an application filed pursuant to this section, the commissioner shall review the application and notify the applicant of any deficiencies in the application.

(d) Within ninety (90) days after the date of receipt of a completed application, the commissioner shall:

(1) Issue a certificate of registration if the commissioner is satisfied that the applicant has

met the requirements of this chapter and any regulations promulgated thereunder; or

(2) Disapprove the application and state the ground(s) for disapproval. The commissioner shall notify the applicant in writing specifically stating the ground(s) for the disapproval. Upon such notification, the applicant may, within thirty (30) days, request a hearing on the matter to be conducted in accordance with the provisions of the "Administrative Procedures Act", chapter 35 of title 42.

(e) Prior to issuance of a certificate of registration by the commissioner, each discount medical plan organization shall establish an Internet website in order to conform to the requirements of subsection 27-73-9(f).

(f) A registration is effective for two (2) years, unless prior to its expiration it is renewed in accordance with this section or suspended or revoked. At least ninety (90) days before a certificate of registration expires, the discount medical plan organization shall submit a renewal application form and the renewal fee. The commissioner shall renew the certificate of registration of each holder that meets the requirements of this chapter and any regulations promulgated thereunder and pays the renewal fee. The renewal application shall be substantially the same as an original application and the renewal fee shall be two hundred fifty dollars ($250) payable to the State of Rhode Island.

(g) The commissioner may suspend the authority of a discount medical plan organization to enroll new members or refuse to renew or revoke a discount medical plan organization's certificate of registration if the commissioner finds that any of the following conditions exist:

(1) The discount medical plan organization is not operating in compliance with this chapter and any regulations promulgated thereunder;

(2) The discount medical plan organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising;

(3) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or

(4) The continued operation of the discount medical plan organization would be hazardous to its members.

(h) If the commissioner has cause to believe that grounds for the non-renewal, suspension or revocation of a certificate of registration exists, the commissioner shall notify the discount medical plan organization in writing specifically stating the ground(s) for the refusal to renew or suspension or revocation. Upon such notification, the discount medical plan may, within thirty

(30) days, request a hearing on the matter to be conducted in accordance with the "Administrative Procedures Act," chapter 35 of title 42.

(i) When the certificate of registration of a discount medical plan organization is non-renewed, surrendered or revoked, the discount medical plan organization shall proceed, immediately following the effective date of the order of revocation or, in the case of a non-renewal, the date of expiration of the certificate of registration, to wind up its affairs transacted under the certificate of registration. The discount medical plan organization shall not engage in any further advertising, solicitation, collecting of fees or renewal of contracts. The commissioner may, in his sole discretion and upon a showing of good cause, in the case of a registration of a discount medical plan organization that has been revoked or non-renewed by the commissioner, allow the discount medical plan organization to continue to operate under any conditions and restrictions established by the commissioner, pending the outcome of a hearing requested pursuant to subsection (h) of this section.

(j) The commissioner shall, in an order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its certificate of registration to enroll members. The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period. The certificate of registration of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The commissioner shall not grant the request for reinstatement if the commissioner finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(k) In lieu of suspending or revoking a discount medical plan organization's certificate of registration, whenever the discount medical plan organization has been found to have violated any provision of this chapter, the commissioner may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to immediately cease and desist from engaging in the act or practice that constitutes the violation; and

(2) Impose any penalty provided for under section 42-14-16.

(l) Each registered discount medical plan organization shall notify the commissioner immediately whenever the discount medical plan organization's certificate of registration, or other form of authority, to operate as a discount medical plan organization in another jurisdiction is suspended, revoked or non-renewed in that state.

(m) A provider who provides discounts to his or her own patients without any cost or fee

of any kind to the patient is not required to obtain and maintain a certificate of registration under this chapter as a discount medical plan organization.

27-73-6. Surety bond or deposit requirements. – (a) Each registered discount medical plan organization shall maintain in force a surety bond in its own name in an amount not less than one hundred thousand dollars ($100,000) to be used in the discretion of the commissioner to protect the financial interest of members, including, but limited to, making refunds of fees and costs to consumers if the registered discount medical plan organization's registration is revoked . The bond shall be issued by an insurance company licensed to do business in this state.

(b) In lieu of the bond specified in this section, a registered discount medical plan organization may deposit and maintain deposited with the commissioner, or at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to the commissioner with at all times have a market value of not less than one hundred thousand dollars ($100,000).

(c) All income from a deposit made under this section shall be an asset of the discount medical plan organization.

(d) Except for the commissioner, the assets or securities held in this state as a deposit under this section shall not be subject to levy by a judgment creditor or other claimant of the discount medical plan organization.

27-73-7. Examinations and investigations. – (a) The commissioner may examine or investigate 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, but not limited to, complaint indices, recent complaints, information from other states, or as the commissioner deems necessary.

(b) An examination or investigation conducted as provided in this section shall be performed in accordance with the provisions of chapter 13.1 of title 27 of the general laws.

(c) In addition to the examination powers provided for in subsection (b) of this section, the commissioner may:

(1) Order any discount medical plan organization or applicant that operates a discount medical plan organization to produce any records, books, files, advertising and solicitation materials or other information; and

(2) Take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest.

(d) The discount medical plan organization or applicant that is the subject of the

examination or investigation shall pay the expenses incurred in conducting the examination or investigation, including, but not limited, to the expenses of attorneys, consultants and other experts. Failure by the discount medical plan organization or applicant to promptly pay the expenses is grounds for denial of a certificate of registration to operate as a discount medical plan organization or revocation of a certificate of registration to operate as a discount medical plan organization. Such expenses, if not paid, may be recovered through a civil action filed in the superior court.

27-73-8. 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) If a member cancels his or her membership in the discount medical plan organization within the first thirty (30) days after the date of receipt of the written document for the discount medical plan described in subsection 27-73-11(e), the member shall receive a reimbursement of all periodic charges and the amount of any one-time processing fee that exceeds ten dollars ($10.00) upon return of the discount medical plan card to the discount medical plan organization.

(c) Cancellation occurs when notice of cancellation is given to the discount medical plan organization. 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 emailed to the email address of the discount medical plan organization.

(d) A discount medical plan organization shall return any periodic charge charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.

(e) 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.

(f) 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 this section.

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

27-73-9. Provider agreements - Provider listing requirements. – (a) 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.

(b) A provider agreement between a discount medical plan organization and a provider shall provide the following:

(1) A list of the medical or ancillary services and products to be provided at a discount;

(2) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

(3) That the provider will not charge members more than the discounted rates.

(c) 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:

(1) Contain the provisions described in subsection (b) of this section;

(2) Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; and

(3) 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.

(d) 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 subsection (c) of this section.

(e) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered.

(f) Each discount medical plan organization shall maintain on an Internet website 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 shall be prominently displayed on all of its advertisements, marketing materials, brochures and discount medical plan cards.

(g) This section applies to those providers with which the discount medical plan organization has contracted with directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

27-73-10. Marketing requirements. – (a) A discount medical plan organization may market directly or contract with other marketers for the distribution of its products.

(b) The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling or distributing the discount

medical plan. 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.

(c) 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.

(d) 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.

(e) Upon request, a discount medical plan organization shall submit to the commissioner all advertising, marketing materials and brochures regarding a discount medical plan.

27-73-11. Marketing restrictions and disclosure requirements. – (a) All advertisements, marketing materials, brochures, discount medical plan cards and any other communications of a discount medical plan organization provided to prospective members and members shall be truthful and not misleading in fact or in implication. An advertisement, any marketing material, brochure, discount medical plan card or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it is reasonably expected to create within the segment of the public to which it is directed.

(b) A discount medical plan organization shall not:

(1) Except as otherwise provided in this chapter or as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount medical plan, use in its advertisements, marketing material, brochures and discount medical plan cards the term "insurance";

(2) Except as otherwise provided in state law, describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insured product and the insurance benefits are incidental to the discount medical plan benefits;

(3) Use in its advertisements, marketing material, brochures and discount medical plan cards the terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is health insurance;

(4) Use language in its advertisements, marketing material, brochures and discount medical plan cards with respect to being "registered" by the health insurance commissioner in a

manner that could reasonably mislead an individual into believing that the discount medical plan is insurance or has been endorsed by the state;

(5) Make misleading, deceptive or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card;

(6) Have restrictions on access to discount medical plan providers, including, except for hospital services, waiting periods and notification periods; or

(7) Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided under the discount medical plan, unless the discount medical plan organization has an active certificate of authority to act as a third-party administrator in accordance with chapter 20.7 of title 27 of the general laws.

(c) Each discount medical plan organization shall make the following general disclosures:

(1) In writing in not less than twelve (12) point font and in a manner that is clear and conspicuous and achieves a grade level score of no higher than eighth (8^{th}) grade on the Flesch-Kincaid readability test;

(2) On the first content page of any advertisements, marketing materials or brochures made available to the public relating to a discount medical plan; and

(3) Along with any enrollment forms given to a prospective member:

(i) That the plan is a discount plan and is not insurance coverage;

(ii) That 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;

(iii) Unless the discount medical plan organization has an active certificate of authority to act as a third-party administrator, that the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;

(iv) That the plan member is obligated to pay for all medical or ancillary services, but will receive a discount from those providers that have contracted with the discount medical plan organization; and

(v) The toll-free telephone number and Internet website address for the registered discount medical plan organization for prospective members and members 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.

(d) If the initial contact with a prospective member is by telephone, the disclosures required under subsection (c) of this section shall be made orally and shall be included in the

initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

(e) In addition to the general disclosures required under this section, each discount medical plan organization shall provide to:

(1) Each prospective member, at the time of enrollment, information in writing in not less than twelve (12) point font and in a manner that is clear and conspicuous and achieves a grade level score of no higher than eighth (8^{th}) grade on the Flesch-Kincaid readability test that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan;

(2) Each new member a document in writing in not less than twelve (12) point font and written in a manner that is clear and conspicuous and achieves a grade level score of no higher than eighth (8^{th}) grade on the Flesch-Kincaid readability test that contains the terms and conditions of the discount medical plan and includes information on:

(i) The name of the member;

(ii) The benefits to be provided under the discount medical plan;

(iii) Any processing fees and periodic charges associated with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

(iv) The mode of payment of any processing fees and periodic charges, such as monthly, quarterly, etc., and procedures for changing the mode of payment;

(v) Any limitations, exclusions or exceptions regarding the receipt of discount medical plan benefits;

(vi) Any waiting periods for certain medical or ancillary services under the discount medical plan;

(vii) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf;

(viii) Cancellation procedures, including information on the member's thirty (30) day cancellation rights and refund requirements and procedures for obtaining refunds;

(ix) Renewal, termination and cancellation terms and conditions;

(x) Procedures for adding new members to a family discount medical plan, if applicable;

(xi) Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the

organization's complaint system, the plan member may contact his or her local state insurance department; and

(xii) The name and mailing address of the registered discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices and file complaints.

27-73-12. Notice of Change in Name or Address. – Each discount medical plan organization shall provide the commissioner at least thirty (30) day's advance notice of any change in the discount medical plan organization's name, address, principal business address or mailing address or Internet website address.

27-73-13. Annual Reports. – (a) If the information required in subsection (b) of this section is not provided at the time of renewal of a certificate of registration under section 27-73-5, a discount medical plan organization shall file an annual report with the commissioner in the form prescribed by the commissioner, within three (3) months after the end of each fiscal year.

(b) The report shall include:

(1) If different from the initial application for a certificate of registration or at the time of renewal of a certificate of registration or the last annual report, as appropriate, a list of the 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;

(2) The number of discount medical plan members in the state; and

(3) 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 shall:

(1) Forfeit:

(i) Up to five hundred dollars ($500) each day for the first ten (10) days during which the violation continues; and

(ii) Up to one thousand dollars ($1,000) each day after the first ten (10) days during which the violation continues; and

(2) Upon notice by the commissioner, lose its authority to enroll new members or to do business in this state while the violation continues.

27-73-14. Penalties. – (a) In addition to the penalties and other enforcement provisions of this chapter or under pursuant to section 42-14-16, any person who willfully violates this chapter is subject to civil penalties of up to ten thousand dollars ($10,000) per violation.

(b) A person that willfully operates as or aids and abets another operating as a discount medical plan organization in violation of this chapter shall, upon conviction, be fined not more than fifty thousand dollars ($50,000) or be imprisoned for not more than one year, or both.

(c) A person that collects fees for purported membership in a discount medical plan, but purposefully fails to provide the promised benefits shall be deemed guilty of larceny and upon conviction is subject to penalties provided for in section 11-41-5. In addition, upon conviction, the person shall be ordered to pay restitution to persons aggrieved by the violation of this chapter. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

27-73-15. Injunctions. – (a) In addition to the penalties and other enforcement provisions of this chapter, the commissioner or the department of the attorney general may seek both temporary and permanent injunctive relief when:

(1) A discount medical plan is being operated by a person or entity that is not registered pursuant to this chapter; or

(2) Any person, entity or discount medical plan organization has engaged in any activity prohibited by this chapter or any regulation adopted pursuant to this chapter.

(b) The superior court shall have jurisdiction over any proceeding brought pursuant to this section.

(c) The authority to seek injunctive relief is not conditioned on the commissioner having conducted any proceeding pursuant to the provisions of the "Administrative Procedures Act", chapter 35 of title 42.

27-73-16. Regulations. – The commissioner may adopt regulations to carry out the provisions of this chapter.

27-73-17. Severability. – If any provision of this chapter, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the chapter, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

27-73-18. Effective Date. – Any discount medical plan organization doing business in or from this state on or after January 1, 2011 shall comply with the requirements of this chapter.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE - DISCOUNT MEDICAL PLANS

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This act would establish standards for discount medical plan organizations, protect consumers from unfair and deceptive marketing practices and facilitate consumer understanding of discount medical plan organizations.

This act would take effect upon passage.

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