

Not Your Father's Health Insurance

Discount Medical Plans and the Health Care Crisis

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The Iowa Policy Project

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The Iowa Policy Project

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EXECUTIVE SUMMARY

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The steady ascent of health care costs, the erosion of job-based health insurance, and the growing ranks of the uninsured and underinsured have conjured up a wide array of products promising health savings or security. These include various “consumer” (nongroup) coverage options, including health savings plans and limited, high-deductible or catastrophic insurance. And they include a profusion of discount medical plans, most of which offer some combination of discounts on ancillary medical services and access to group or “preferred provider” rates on conventional (doctor and hospital) medical services.

The real value of discount cards is unclear — and obscured by the industry's marketing structure and billing practices. But given a typical annual cost of about \$400/year, plan subscription would only begin to pay off after an accumulation of over \$2,000 in medical expenses. Much beyond that, especially in the event of catastrophic expenses, discounts would either make little difference or disappear upon failure to pay at time of service. Because they offer little benefit for those with light medical expenses and no security for those with substantial expenses, the likelihood that discount medical plans “pay off” for health consumers is slim.

The future of these plans, in the wake of health reform, is unclear — and will depend largely on the pace and terms of its implementation. What is clear, as of this report, is the legion of problems that accompany this sprawling and unevenly regulated industry. These include:

- Aggressive and deceptive marketing practices which suggest or imply conventional insurance coverage, or exaggerate the savings or discounts offered;
- Sweeping claims of access to “participating providers,” often in the absence of any clear agreement or commitment by listed providers to honor the plan's discounts or commitments; and
- Elusive benefits — given plan costs and provider participation — for most plan members.

These problems are especially pronounced at the industry's margins — where discount plans are re-packaged and re-priced by third-party brokers.

Many states have stepped in to regulate the worst of these practices. State laws governing discount medical plan organizations (DMPOs) offer a range of provisions, including:

- varieties of “this is not insurance” disclosure in marketing materials;
- registration of plans with the state insurance commission;
- filing and/or disclosure of agreements with providers, provider networks, and third-party marketers;
- cancellation rights;
- assurance of financial security (bond or statement of net worth);
- annual reporting.

Although 30 states now have DMPO laws on the books, only a few offer the full range of these provisions, and enforcement depends largely on the capacity or aggressiveness of each state's insurance commission or attorney general.



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Introduction

The dimensions of our health care crisis are familiar and daunting. The reach of job-based coverage is slipping — a reflection of spiraling costs, long-term shifts in employment, and broader economic insecurity. For the last generation, employment growth has been concentrated in sectors that do not offer employment-based coverage. And job losses, in this recession and the last, have fallen disproportionately on those sectors where job-based coverage was the strongest. Job-based insurance premiums have more than doubled since 2000, a burden which has driven down the rate at which employers offer insurance, swollen out-of-pocket spending (in the form of premium shares, copayments, and deductibles), and — as a result — eroded the rate at which employees “take up” job-based insurance for themselves or their families.¹ High costs weigh even more heavily for those not covered at work. Spending on premium and services is growing twice as fast for those who rely on private, nongroup insurance. Health spending is now a leading source of household debt and financial insecurity. Even before the onset of our current recession, nearly one in five Americans reported that health costs represented a significant financial burden.²

The net result, most notoriously, is steady growth in the ranks of the uninsured (now roughly 50 million Americans). Uninsurance is nearly double the national rate for young adults, Latinos, families living at less than 200 percent of the poverty line, part-time workers, low-wage workers, and workers in small firms. Across our last business cycle, coverage slipped during good times and bad — although the recession has made things much worse: Persistently high unemployment and further retreat in employer-based coverage added 4.3 million to the ranks of the uninsured in 2009 alone. Even assuming a full recovery, the number of uninsured is projected to top 60 million in the next decade.³ At the same time, we are witnessing steady growth in the ranks of the *underinsured*. Employers have both retreated from coverage and “thinned out” (by covering less and paying a smaller share) the coverage they do offer. Non-group coverage is — as a rule — harder to get, more expensive, less secure, and less comprehensive.⁴

These conditions animated the passage of federal health reform in 2010 that, once (or if) fully implemented, promises to make coverage more accessible and affordable.⁵ But they have also encouraged a sprawling and unregulated market of sham coverage. As costs rise and coverage contracts, many observers (including the General Accounting Office, the Federal Trade Commission, State Insurance Commissions, and local and state Better Business Bureaus) have noted a surge in the marketing of bogus insurance products. This problem has worsened with the recession as the combination of slipping coverage and rising employment has created “an ideal breeding ground for scams.” And it has worsened with the passage of health reform, as unscrupulous marketers play on public confusion.⁶

Discount Medical Plans

The most prevalent of these products is the *discount medical plan*. Discount medical plans first appeared in the 1990s, and were originally designed to offer discounts on ancillary medical services not covered by conventional insurance. They provided a sort of “buyers’ club” access to discounted rates on prescriptions, dental care, eye care, chiropractic services, and alternative health services. Such plans are still common, but many now offer (or promise) similar discounts on conventional medical expenses. In their early form, discount medical plans combined access to the same provider networks used by insurance companies with a system of escrowed pre-payment for services. When presented with a discount card, participating providers could verify the discount rates, and verify the patient’s ability to pay. Most discount medical plan organizations (DMPOs) soon abandoned the prepayment feature, which both made the plans too expensive to market successfully and — by mocking the features of conventional insurance — attracted the attention of state insurance commissioners.⁷

This left DMPOs with a relatively simple line of business — buying and selling access to provider networks and their discounted rates. This market was created, in part, by the profusion of preferred provider organizations (PPOs) that accompanied the fascination with “managed competition” in health care in the 1980s and 1990s. Initially, PPOs were local or regional networks, representing contracts between group purchasers (usually insurance companies, health maintenance organizations, or self-insured employers) and providers. Under such agreements, providers agreed to a discounted schedule of rates and utilization review in exchange for a stable or increased market for their services.⁸

Over time, a few companies began to cobble together national networks, by acquiring or establishing working relationships with local or regional PPOs. The industry leaders include New York-based MultiPlan (which claims 500,000 providers); California-based Beech Street (560,000 providers); Michigan-based Three Rivers (550,000 providers); and California-based Galaxy Health (400,000 providers). Well over half of the country’s physicians belong to at least one of these networks.⁹ Discount medical plans contract with PPOs on the same terms as large insurers, with the goal of selling network discounts to cash (uninsured) patients. According to Care Entrée, a leading DMPO,

We offer savings on healthcare services throughout the United States to persons who are uninsured or under-insured. These savings are offered by accessing the same preferred provider organizations (PPOs) that are utilized by many insurance companies. These programs are sold through a network marketing strategy under the name Care Entrée and through third party marketers under their own brand names. We design these programs to benefit healthcare providers as well as the network members. Providers commonly give reduced or preferred rates to PPO networks in exchange for steerage of patients. However, the providers must still file claim forms and wait 30 to 60 days to be paid for their services. Our programs utilize these same networks to obtain the same savings for the Care Entrée program members. However, the healthcare providers are paid immediately for their services and are not required to file claim forms.¹⁰

The costs and terms and benefits of medical discount plans vary widely — a bewildering diversity that reflects the origins and structure of competing plans.¹¹ Most cards are marketed directly to uninsured or underinsured consumers. Many of these reflect their roots in the provision of ancillary medical discounts, and offer savings on services such as dental, vision, and chiropractic. Some of these have added (through contracts with PPOs) discounts on medical services but many promise “health savings” based solely on ancillary discounts. Most plans offering actual medical discounts operate as conventional DMPOs, connecting their customers to provider networks. Some, usually those built around local clinics or networks, instead offer “panel” pricing for a limited range of basic medical services. A few firms (CHCS and Agelity, for example) specialize in the coordination and administration of senior benefits — including conventional insurance, discount plans, and Medicare. And even conventional health insurers offer discount card products: Aetna, for example, offers its “Vital Savings” discount plan as a supplement to regular coverage. Blue Cross/Blue Shield of Florida contracts with Coverdell (a leading DMPO) to sell its “Family Blue Discount Card” in Florida CVS stores.¹²

Most of the leading DMPOs offer “turnkey” or “embedded” plans to organizations (such as AARP or AAA) and employers. These carry the brand of the sponsoring organization, and are usually rolled into other membership fees or premiums. While individually marketed plans cost in the range of \$30.00-\$50.00/month, turnkey plans are sold to sponsoring organizations or employers at much lower rates — typically \$2.00-\$6.00/month per enrolled member. Indeed, the bulk of the business of the industry leaders lies in their administration of these turnkey plans.¹³ In fiscal 2007, for example, Access USA (which distributes discount plans under the brands Capella and Protective Marketing Enterprises) listed just over 63,000 plan members; of these, nearly 80 percent (49,019) were “wholesale” customers earning the company an average revenue of less than \$1.00/month per member. And most of these (given the low revenues) were probably non-medical (dental, vision, drug) plans designed to accompany conventional job-based insurance.¹⁴

The industry has seen a great deal of consolidation in recent years, and is dominated by a core of leading firms. Of the 75 plans surveyed in July 2010, 11 (AccessOne, Alliance, AmeriPlan, Association Health Care Management, Careington, Coverdell, HealthTran, International Association of Benefits, New Benefits, Patriot Health and Vantage America) were registered as DMPOs in at least 10 different states. These firms also form the core membership of the Consumer Health Alliance (CHA), the industry trade association.¹⁵ The prominence of these firms is also evident in those states where plans are required to report membership. In Indiana, there are 18 registered DMPOs. Of these, five CHA firms (Alliance, Careington, Coverdell, New Benefits and Vantage) account for over 94 percent of DMPO cardholders in the state.¹⁶ In Florida, there are 26 registered DMPOs. Of these, six CHA firms (Alliance, Careington, Coverdell, Health Allies, New Benefits and Vantage) account for almost 97 percent of cardholders.¹⁷

At the same time, it is a ragged and sprawling industry. In part, this reflects its unscrupulous fringes, in which fly-by-night membership plans have become common targets of attorneys general and insurance commissioners. And it reflects the unevenness of state regulation (discussed at greater length below). Many plans operate in only a few states, and many multistate plans operate under different names in different states. And in part, it reflects the often bewildering ways in which plans are branded and marketed. Even in local markets, discount cards employ multiple labels and brands — often in a race to snap up registered names and web domains.¹⁸ Leading DMPOs and the PPOs offer turnkey or branded plans to a wide array of employers, organizations, buyers clubs, and second-tier marketers. The Galaxy Net PPO, for example, currently recognizes 1,052 different discount cards, ranging from generic brands (“Affordable Health Card,” “Care Saver” “Family Health Card”) to local logos (“Brunswick Bowling,” “Lenny’s Sub Shop”). Of this list, over 100 are turnkey plans administered by New Benefits.¹⁹

Given the wide range of discount cards and the benefits offered, it is difficult to pin down the scope of the industry. Company estimates offer a snapshot, but do not distinguish between those enrolled in discount medical plans and those enrolled in other products: Best Benefits claims 680,000 enrollees; Precis (the parent company for the Care Entrée card) 81,000; Alliance Health Card, 1,105,000; Access (Capella), 88,000. At the time of its recent licensure in California, Family Care claimed “tens of thousands” of members.²⁰ The Consumer Health Alliance claims it serves more than 28 million customers, including about 2 million in Florida and 6 million in California (states in which many of the plans originated). But estimates are that only 5 percent to 10 percent of these plans include discounts for conventional (doctor and hospital) medical expenses, putting the number of medical discount plan members at between 1 million and 3 million nationally.²¹

State-level registration and reporting offer a little more precision. As of December 2009, there were 18 DMPOs registered in Indiana, claiming an aggregate membership of 102,980. Of these, four are dental-only plans and one (CHCS) administers eldercare programs — leaving 13 conventional DMPOs with a membership of about 95,000. There were 26 registered DMPOs in Florida, claiming an aggregate

membership of 1,709,178. And there were 18 registered DMPOs in West Virginia, claiming an aggregate membership of 78,473 (removing the dental and eldercare plans drops this slightly to 47,097).²²

But, for a number of reasons, these are difficult numbers to extrapolate. The reporting states represent three very different economic and demographic settings: Florida is a populous state, with a workforce heavily skewed toward services and health care. Its elderly population (at 18 percent) represents a high share of the population. And its rate of uninsurance (at 20 percent) is steep. Indiana is a struggling rustbelt state, its rates of elderly population (12.9 percent) and uninsurance (12.3 percent) close to national averages. West Virginia is a much smaller state, its economy dominated by mining and manufacturing; its rates of elderly population (15.8 percent) and uninsurance (15.0 percent) running just ahead of national averages. The discount medical industry is much more firmly established in Florida and enrollment rates (as a percentage of the civilian labor force or of the uninsured) run much higher than those of Indiana and West Virginia. And it is difficult to gauge what share of discount plan enrollment is captured by annual reporting, an exercise undoubtedly avoided by the industry fringes.²³

Other sources are of uneven help in pinning down the prevalence of medical discount cards. National household surveys do a notoriously poor job of measuring anything but the rough parameters of coverage, as even astute respondents are often unable to untangle the terms (deductibles, spending caps, exclusions) of their insurance.²⁴ In our 2005 survey of nonstandard workers (representing 34 million workers, or about one quarter of the 2005 U.S. workforce) we found an uninsurance rate of 24 percent (nearly double that of the rate for standard workers). About the same number reported subscription in a medical discount plan, most of which (18 percent of the total) listed this as their only form of “insurance.”²⁵ This would suggest a discount card enrollment among nonstandard workers alone of about 8 million. If we assume the same discount card subscription rate (running roughly equal to the uninsurance rate) for standard workers, this would add another 12 million subscribers. Since we can assume that most of these plans offer discounts on only ancillary services, the incidence of actual medical (doctor and hospital) discount cards — by this measure — falls within the same 1 million to 3 million range.

In our 2009 survey (prompted by surprising frequency of discount card uses reported in 2005), 8.4 percent of all respondents indicated that they had a medical discount card. This rate was slightly higher for those employed (8.97 percent) and for those employed *and* insured (10.35 percent). And 4 percent of employed and insured respondents listed the medical discount plan as their only form of insurance. These results confirm the general picture, but also underscore the prevalence of ancillary service discount cards marketed to accompany conventional insurance. Most (65 percent) of the discount cards held by employed respondents were provided by the employer or union rather than purchased on the private market.

The terms and benefits of these plans vary widely. Almost all plans begin with a laundry list of discounts on ancillary services (dental, vision, chiropractic, prescription, alternative); some stop there, others also offer discounts on doctor and hospital charges — often in a “premium” or “gold” plan. Alongside the promised discounts, plans often include other benefits and services which are difficult to value or assess — such as “24-hour nurse hotline assistance,” patient advocacy, online health services (basic medical information or provider search engines), “VIP health and wellness,” or billing negotiation and mediation services.²⁶ Some plans offer flat rate pricing on basic services (such as screening or blood tests). And some offer discount plans bundled with catastrophic (accidental death and dismemberment) or limited benefit insurance products.²⁷

Advertised discounts also vary widely. The standard marketing pitch cites discounts “up to” 50 or 80 percent, but the high end is almost tied to the regular retail price of selected services such as blood tests.

Of the plans surveyed, 18 made specific claims as to discounts, most citing savings of between 10 and 50 percent on doctor and hospital charges. Remarkably, considering that the plans are offering access to the same provider networks, very few made the *same claims*. The 18 plans cited 12 different discount rates, including a range from “10 to 60 percent” to “10 to 20 percent,” and a few that promised slightly smaller (15 or 20 percent) average or guaranteed savings.

Costs also vary, although not as widely. Of the surveyed plans, 28 listed clear financial terms. Half of these offered an individual medical discount plan (including doctor’s and in most cases hospital services) for between \$19.95 and \$29.95 a month (only a few of these offered family coverage for a higher rate). Only one plan was priced lower, charging an annual fee of \$129.95. A few fell into the \$40.00 range although there is no appreciable difference in the benefits, network access, or discounts provided by these plans.²⁸ Much of the disparity in pricing reflects the way in which plans are sold, as much of the business is conducted by third-party marketers who re-brand and re-price the plans and programs of leading firms such as New Benefits or Careington.²⁹ Two plans offer family-only coverage (priced at \$39.95 and \$59.95 respectively). Those plans at higher price points (five plans at between \$80 and \$250/month) all combined medical discounts with catastrophic or limited health insurance coverage. Most plans also charge a onetime membership or enrollment fee, most commonly \$30.

Problems

This is a sprawling and lightly regulated industry. At its worst, marginal and unscrupulous firms have prompted thousand of consumer complaints, state investigations, and legal actions. The Consumer Health Association exists largely to sustain and build confidence in an industry in which, as one member admitted in 2005, there are “lots of bad players right now ... total scams.”³⁰ But even at its best, industry leaders have struggled to deliver on often sweeping claims of health savings. These problems — identified and documented by investigators for the General Accounting Office (February 2004), the State of Maryland (November 2004), the Commonwealth Fund (March 2005), the State of Florida (November 2006), and numerous state insurance commissions, better business bureaus, and attorneys general — fall into three areas: deceptive marketing, uneven participation by providers, and elusive benefits.³¹

Deceptive Marketing

Investigators have identified a range of fraudulent or deceptive marketing practices. The most common complaints, directed particularly at fly-by-night marketers of discount plans, are unauthorized enrollment, unauthorized charges, or unwillingness to cancel a plan (and its monthly fee). Membership organizations, which offer discount medical plans as one of a number of benefits, have used “cramming” or a “negative option” (by which members must explicitly decline the plan in order to avoid charges) to sign up unsuspecting consumers. High-pressure sales tactics include soliciting credit card or checking account numbers for the purpose of “prequalifying” consumers, and then immediately pushing through enrollment and monthly charges.³² The passage of health reform has added a new twist to all of this. One plan’s late-night TV ad features an image of the White House and the words: “Healthcare Alert! Daily registration limits have been established for all Americans seeking affordable access to healthcare. Register now for immediate acceptance.” In Missouri, the State Insurance Director was forced to issue a warning about door-to-door salesmen claiming to be federal agents selling insurance under the new law. Colorado insurance regulators received complaints about scam artists going door-to-door selling “ObamaCare” insurance policies and claiming there was a limited open-enrollment period to buy health insurance.³³

These practices are enabled by the industry's structure, in which even the mainstream plans are sold and resold, branded and rebranded, down a pyramid of third-party vendors and marketers. As one company prospectus describes it: "Our distribution channels currently include network marketing representatives, independent agents and consumer direct tele-sales call centers. We also market to internet portals and financial institutions and wholesale lease some of our programs."³⁴ Faced with consumer complaints, vendors invariably claim to have been duped by the parent plans while parent plans claim that independent vendors have oversold the product and its benefits.³⁵ "A lot of vendors are misrepresenting the product," as one DMPO executive observes, "It's so easy to sell a service over the Internet or put together a slick marketing brochure."³⁶ In turn, a number of discount plans operate as pyramid schemes, in which brokers earn more by recruiting more brokers than they do by selling plans.³⁷

Plans also play fast and loose with familiar insurance concepts and terms. Many plans use terms like "medical discount" or "health savings" in reference to a range of services *not including* those provided by an actual doctor or hospital. About one in five (14 of 75) of the surveyed plans advertised medical coverage discounts but only offered discounts on prescription, vision, dental, chiropractic, and alternative care. And most of the true medical discount plans offer a lower-tier plan as well that covers only these ancillary services.

More seriously, especially for state insurance regulators, discount plans routinely posture as insurance — even as state regulators increasingly require explicit disclosures that they are not. Many states report instance of discount plans being sold as insurance.³⁸ In its 2006 survey, the Maryland Insurance Commission found the majority of its complaints regarding discount plans came from consumers who thought they had purchased insurance. Marketers often claim that the plan is "underwritten" by a conventional insurance company, or imply that the participating PPO (Beech, Galaxy) is an insurance company. In one Colorado case, the DMPO trumpeted (in fax solicitations) that "This is Health Insurance — Not Discount Health Care" and issued "insurance cards" to its members.³⁹

Most plans stop short of such bald claims, relying instead on a marketing patter of familiar insurance terms and concepts. References to "coverage," "pre-existing conditions," "open enrollment," "deductibles," "co-pay" and "premiums" are routinely employed to confuse consumers. "Our Retail Plans Division offerings include healthcare savings plans and association memberships that are not insurance," as one DMPO puts it, "*but provide insurance features and benefits.*"⁴⁰ Many plans also bundle features in order to elide the difference between actual insurance and discount plans — typically adding medical discounts to catastrophic or limited benefit insurance in such a way as to parrot the coverage of conventional health insurance.⁴¹

Phantom Providers

The only real value of a discount medical plan is its access to provider networks (PPOs) and their discount rates. PPOs were originally designed to package these networks and discounts for insurance companies and large self-insured companies, but the large national PPOs (PCHS, Beech, Galaxy) began to sell access to third-party brokers, including discount plans.⁴² This raises a number of problems for providers. First, doctors and hospitals represented as participating in discount plans (usually accessed through a search engine on the plan's website organized by locality and specialty) are often unaware of their participation — not surprising given the ways in which cards are marketed and branded (remember, Galaxy Health list over 1000 cards affiliated with its network).⁴³ Many DMPOs have drawn the attention of state insurance commissions or attorneys general for claiming direct provider contracts when most of these were, at best, second-hand: Local providers belonged to a national PPO; the national PPO sold its logo and lists to the discount plans. In many cases, provider participation was so spotty that state courts deemed the plans listing them "a worthless and sham product."⁴⁴

More importantly, providers often resent or resist participation. Most understand PPO contracts as an agreement to offer discount rates on services in exchange for the referral of *insured* patients. It is one thing to bill a conventional health insurer for services offered at the PPO rates; cash patients claiming the discount are a much riskier proposition. Doctors have sued DMPOs and PPOs for appropriation of their names to sell discount plans, and for assuming their participation in a plan that markets the discount without any commensurate assurance of payment. A few plans, in a concession echoing the experience of consumers in membership plans, have begun to allow doctors to opt out.⁴⁵

All of this means, of course, that enrollees also struggle to find participating providers. Common complaints to consumer watchdogs and insurance commissions include providers unaware of their participation, providers unwilling to honor the promised discount, and inflated or inaccurate provider lists. “The company had a website you could turn to [to] find who participates and some of the participants listed were out of business,” notes a recent investigation by the North Alabama Better Business Bureau, “Others we talked to were not even familiar with this program and said they do not participate.” A similar investigation in Milwaukee called the first 20 providers on one DMPO’s list: nearly half of the numbers were incorrect or out of service, and only one the remainder (chiropractor) said their office would accept the card. “Good luck finding a doctor who accepts the card,” it concluded bluntly.⁴⁶

Costs and Benefits

It is difficult to cleanly assess the value of a discount card, which is shaped by varying costs, uneven provider participation, and a wide range of utilization by enrollees. Certainly many of the more marginal plans — judged by the sheer volume of consumer complaints on this score — make much of their money through aggressive sales, hidden or nonrefundable fees, and foot-dragging on cancellations.⁴⁷

Academic, legal and regulatory investigations document a wide range of tactics by which promised discounts of “up to” 50 percent or 80 percent prove illusory. In many plans, the combination of enrollment fees, monthly fees, and co-payments make it nearly impossible for the consumer to come out ahead: In a Maryland plan promising “\$10 dollar doctor visits,” the \$10 was actually a copayment. The plan paid the next \$40 of the charges, and then billed the patient’s credit card or bank account for 80 percent of the remainder. The plan limited the enrollee to 12 annual visits, leaving it on the hook for no more than \$480 (12 times \$40). The cost of the plan (on top of all the out-of-pocket charges) was \$80/month, or almost \$1,000.⁴⁸ In other instances, administrative fees accompanied every discount, substantially eroding the promised savings. Or plans required patients to pay in full at the time of service in order to qualify for the discount, erasing the benefit for those most likely to need it.⁴⁹

The tenuous relationship between plans, providers and patients also serves to diminish plan value. DMPOs, despite claims to the contrary, do not have contracts with providers. The result, as the Texas attorney general concluded in one case, is that a plan “has no knowledge of what the individual health care providers would charge patients who pay cash for their services at the time of receiving the service, and therefore has no knowledge of the amount, or even the existence, of any discount.” Many providers offer discounts to cash customers anyway, rendering the discount card (and its costs) unnecessary.” In some cases,” as the Texas AG concluded, “the health care provider’s fee schedule which would be utilized for “cash” patients, is the same as, or even less than, the network fee schedule.”⁵⁰

Taken together, the industry’s byzantine billing practices and inflated claims (as to savings and provider cooperation) render the plans’ real value doubtful. This was documented by the 2005 investigation by Kofman and co-authors, who purchased five cards, presented them to providers and then canceled them. Only two of the five cards (the least expensive of those selected) offered any measure of value, and only one offered both demonstrable savings and reliable access to listed providers.⁵¹ The industry’s pricing

has converged since 2005: Kofman's plans ranged from \$24.95 to \$89.95 month, with enrollment fees from \$10 to \$120; most plans surveyed for this study were priced at \$19.95, \$29.95, or \$44.95, with enrollment fees of \$30 now standard. A typical plan, in other words, would cost about \$400 a year. If we assume reliable provider discounts of 20 percent, the plan would begin to pay off after the accumulation of \$2,000 in annual expenses. But much beyond that, especially in the event of steep hospital charges,⁵² discounts would either make little difference or disappear upon failure to pay at time of service. Because they offer little benefit for those with light medical expenses and no security for those with substantial expenses, the likelihood that discount medical plans "pay off" for health consumers is slim.

Regulatory Challenges and Dilemmas

In recent years, states have paid closer attention to the inflated claims, limited benefits and aggressive marketing of discount medical plans. But consistent and effective state action is hampered by the very nature of the plans: These plans are not insurance, and one of the principal state concerns is to control claims or implications that they are. But because these plans are not insurance, state regulatory authority is uncertain. State insurance commissions have in some cases hewed to the view that they hold no jurisdiction over a product that is not insurance, while in other cases (more commonly and recently) have claimed that they have clear authority to rein in schemes that masquerade as insurance.⁵³ The task, as one observer notes wryly, "is like playing regulatory whack-a-mole."⁵⁴

Jurisdiction over DMPOs is typically shared by the state insurance commission or department, and the office of the state attorney general. Only in California, whose Department of Managed Health Care regulates health care more closely than most state insurance commissions, are DMPOs accorded the same status (and scrutiny) as conventional health insurance.⁵⁵ In most other states with explicit licensing or regulation of DMPOs, the terms are typically laid out in the insurance code, while violation of those terms (usually fraudulent business practices) are enforced by the attorney general's office.⁵⁶ In some states, regulation of DMPOs has been written into the business practices or consumer protection code, where enforcement falls directly to the attorney general.⁵⁷

Finally, the presence or absence a DMPO law is not necessarily a reliable marker of the protections afforded consumers in that state. Some state DMPO laws impose only minimal disclosure requirements while confirming exemption from other aspects of the insurance code.⁵⁸ In those states without a specific statute on the books, DMPOs are still subject to state consumer protection or business practice codes, which typically regulate marketing claims and practices, cancellation rights, and the like. In New York, for example, the attorney general's office has issued guidelines that replicate much of disclosure language of DMPO laws in other states.⁵⁹ And, without or without a DMPO law, enforcement often hinges on the pace of consumer complaints or the aggressiveness of the attorney general's office.⁶⁰

Regulation has spread rapidly in recent years. As of 2004, the industry estimated that about 20 states had a DMPO law on the books, most of which mandated basic "this is not insurance" disclaimers in advertising materials.⁶¹ The most expansive of these early interventions was in Florida, whose 2004 law added licensing and registration, oversight of provider and marketing contracts, cancellation rights, security requirements, and annual reporting (these provisions are explained in greater detail below).⁶² As of July 2010, 30 of 51 state jurisdictions (including the District of Columbia) had enacted some form of regulatory oversight of discount medical plans (see Appendix A).⁶³

Disclosure

The most prevalent (found in all 30 state DMPO laws) provision of state law regulates or restricts the claims that can be made by discount plans. Almost all of these require disclosure, on the discount card itself, "in bold and prominent type that the discounts are not insurance."⁶⁴ Most states extend this

requirement to all marketing materials, and a few to the scripts of telephone solicitations as well. In addition, states have sought to minimize the potential for consumer confusion by prohibiting states from using common insurance terms, or (Utah) “any form of words or terms that may confuse health discount programs with other types of health insurance.”⁶⁵ In these states, a plan cannot (quoting here the Louisiana law) “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 mislead an individual into believing that the discount medical plan is health insurance.”⁶⁶

Many states take these “truth in advertising” prohibitions a step further. Alaska bars “misrepresentation and false advertising of insurance policies” including the implication that “a health discount plan is a form or type of insurance,” description of a plan “using common insurance terminology,” and any suggestion that “a health discount plan is underwritten by or associated with an insurer.”⁶⁷ In a few cases, states extend this to the use of language which implies that a plan is regulated by the insurance commission “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” (South Dakota).⁶⁸ Plans in Utah cannot refer to sales representatives as “agents, producer, or consultants.”⁶⁹ In North Dakota and a handful of other states, noninsurance disclosures are underscored for plans which are bundled or offered alongside conventional insurance products.⁷⁰ And few states mandate full disclosure of plan terms, requiring notice (as in Florida) that plans are not insurance, that they do not make payments to providers, and that plan members are obligated to pay for services.⁷¹

Provider Agreements

The next most common provision is the documentation of provider agreements. In 2004, eight states required plans to have signed contracts with providers before they could list them as participants in the plan.⁷² By 2010, 28 states included this provision, typically mandating that each plan (quoting Connecticut code) “maintain a copy of each active agreement that it has entered into with a provider or provider network”⁷³ Because such contracts are most commonly between a discount plan and a provider network (PPO), their requirement has done little to alleviate the confusion of providers belonging to the network but unaware of (or unhappy with) its relationship with various discount plans. Only a few states offer stricter guidelines. Florida and New Hampshire require that each agreement include a list of discounted services and the discount rate (or an equivalent fee schedule) and, more importantly, that contract terms be replicated in written agreements between provider networks and their providers.⁷⁴

Licensing and Registration

Many states (20) now require that DMPOs go through a registration or licensing process, and most of these make lists of companies licensed or registered in that state available online. The scope and demands of the licensing process vary widely. Some states (Arkansas, for example), require only the registration of a local agent. At the other pole, some states treat DMPOs as the equivalent of conventional health plans, and invoke the same registration standards: in California, DMPOs are considered “health service plans” under the state’s managed care act; in Illinois, DMPOs are subject to the same regulatory scrutiny as all PPO administrators.⁷⁵ Most states with a DMPO registration or licensing provision require a simple registration, involving little more than a standard form and an application fee (usually \$250-\$500), although the state office (usually the insurance commission or division) has wide investigatory latitude during the approval process.⁷⁶ In a few states, the registration or licensing process is more elaborate — and includes a standard application, copies of relevant corporate documents (bylaws, articles of incorporation, financial statements) copies of contracts with providers

and third-party marketers (including contact information for the latter), and biographical information on company officers, directors and significant stockholders.⁷⁷

Cancellation

Many states (19) also lay out cancellation rights in their DMPO laws, typically a “lemon-law” provision that gives consumers the right to cancel — with full or partial refund — usually within a 30-day window. Most of these states also require that cancellation rights be fully disclosed in plan marketing or registration materials.⁷⁸ In almost all states (and perhaps accounting for the uneven inclusion of cancellation provisions in those with DMPO laws), such provisions simply reinstate or reinforce a basic feature of state consumer protection codes.

Bonding or Net Worth

Some of the more rigorous state laws (11 in all) also require some certification or guarantee of financial stability. Eight states require that registered DMPOs post surety bonds, ranging from \$20,000 (South Dakota) to \$100,000 (Connecticut), with most (including Florida, Indiana, Kansas, Montana, West Virginia and Washington) at \$35,000 or \$50,000. In Illinois, the bond is set as a percentage of the plan’s reimbursement rate. A few states require that plans document their net worth as a condition of registration, a threshold set at \$100,000 in Nevada, \$150,000 in Missouri and Oklahoma and Florida, and \$250,000 in Connecticut.⁷⁹ The Florida net worth provision is the only one to accompany a bonding requirement.⁸⁰ In Connecticut, DMPOs can elect either the \$100,000 bond or the \$250,000 net worth provision.⁸¹

Marketing Agreements

While most states require DMPOs to document their agreements with providers, only a few (eight as of July 2010) require them to do the same for their marketers. This is an important regulatory tool, since so many consumer complaints stem from the tactics of, or the claims made by, third-party vendors of discount plans. The standard marketing provision, found with slight variations in Florida, Indiana, Ohio, South Dakota, Washington and West Virginia, requires DMPOs to file copies of their agreements with marketers, and holds the parent DMPO responsible and liable for the business practices of its secondary marketers.⁸² Texas has a slightly weaker version, requiring only a full list of marketing agents authorized to sell or resell the plans of DMPOs registered with the state.⁸³ In Connecticut, the marketing provision is strengthened by the prohibition of sales under any name or label other than that of the parent DMPO.⁸⁴

Annual Reports

Finally, a handful of states (Florida, Indiana, West Virginia and Washington) impose an annual reporting requirement. The reporting terms in Florida, Washington and West Virginia are identical: Each requires an annual report including audited financial statements, any changes (since last registration) in the names and addresses of all persons “responsible for the conduct of the organization’s affairs,” and a tally of the number of discount plan members in the state. Annual reports must be filed within three months of the end of the fiscal year, enforceable by fines of \$500/day for the first 10 days and \$1,000/day thereafter.⁸⁵ Indiana Code replicates all of these reporting requirements, with the exception of the financial statement.⁸⁶

State	regulatory provisions										notes	
	disc	reg	prov. cont.	mark. cont.	canc.	ann. rep.	bond	reg. auth.	DMPO law			
Alabama	no specific DMPO regulation											
Alaska	X		X					IC	Aug-06			
Arizona	no specific DMPO regulation											
Arkansas	X	X	X		X			AG	Jan-99			
California	X	X	X					IC	Jan-09	DMPO's "health plans" under existing law		
Colorado	X		X		X			AG	Jan-04			
Connecticut	X	X	X	X	X		100k	IC	Jul-05	net worth of 250k in lieu of bond		
Delaware	no specific DMPO regulation											
Dist. of Columbia	no specific DMPO regulation											
Florida	X	X	X	X	X	X	35k	IC	Jan-04	net worth of 150k		
Georgia	X		X					IC	May-06			
Hawaii	no specific DMPO regulation											
Idaho	X		X					IC	May-03			
Illinois	X	X	X				*	IC	Apr-04	*bond set at 10% of reimbursement rate		
Indiana	X	X	X	X	X	X	35k	IC	Mar-06			
Iowa	no specific DMPO regulation											
Kansas	X		X				50k	IC	Jan-02			
Kentucky	X		X					IC	Jul-02			
Louisiana	X	X	X		X			IC	Jan-09			
Maine	no specific DMPO regulation											
Maryland	X	X	X		X			IC	May-07			
Massachusetts	no specific DMPO regulation											
Michigan	no specific DMPO regulation											
Minnesota	no specific DMPO regulation										limited regulation of drug plans only	
Mississippi	no specific DMPO regulation										Jun-07	2007 disclosure law repealed in 2010
Missouri	X	X	X		X			IC	Jul-07	required net worth of 150k		
Montana	X	X	X		X		50k	IC	Oct-05			
Nebraska	X	X			X			IC	Jul-08			
Nevada	X	X	X				*	IC	Jan-06	\$500 annual fee; net worth of 100k		
New Hampshire	X	X	X		X			IC	Jan-09			
New Jersey	no specific DMPO regulation											
New Mexico	no specific DMPO regulation											
New York	no specific DMPO regulation										nd	AG office has issued guidelines
North Carolina	no specific DMPO regulation											
North Dakota	X		X		X			IC	Jun-07			
Ohio	X		X	X	X			IC	Mar-07			
Oklahoma	X	X	X		X		*	IC	May-09	net worth of 150k		
Oregon	X	X	X		X			IC	Jun-07			
Pennsylvania	no specific DMPO regulation											
Rhode Island	no specific DMPO regulation											
South Carolina	X	X	X		X			AG	Aug-06			
South Dakota	X	X	X	X	X		20K	IC	Jan-06			
Tennessee	X							IC	Jun-01			
Texas	X		X	X				IC	Apr-09			
Utah	X	X	X					IC	Jun-05			
Vermont	no specific DMPO regulation											
Virginia	no specific DMPO regulation											
West Virginia	X	X	X	X	X	X	35k	IC	May-09			
Washington	X	X	X	X	X	X	35K	IC	Jul-09			
Wisconsin	no specific DMPO regulation											
Wyoming	no specific DMPO regulation											

¹ On job-based insurance, see Jon R Gabel, [Job-based health insurance, 1977-1998: The accidental system under scrutiny](#),” Health Affairs (Nov/Dec 1999) Vol. 18, Iss. 6; pg. 62, 13 pgs; Kaiser Family Foundation and the Health Research & Educational Trust (HRET), [2009 Employer Health Benefits Survey](#) (September 2009); Elise Gould, [Decline in employer-sponsored health coverage accelerated three times as fast in 2009](#), Economic Policy Institute (September 2010); Elise Gould, [The Erosion of Employer-Sponsored Health Insurance in 2008](#) (EPI, 2009); Elise Gould, [Employer-Sponsored Health Insurance in the 21st Century](#) (EPI, 2009); Ben Furnas, [“American Health Care Since 1994: The Unacceptable Status Quo,”](#) (Washington: Center for American Progress, 2009).

² On costs, see Jon R. Gabel, Roland McDevitt, Ryan Lore, Jeremy Pickering, Heidi Whitmore and Tina Ding, [“Trends In Underinsurance And The Affordability Of Employer Coverage, 2004–2007,”](#) *Health Affairs* 28: 4 (2009): 595-606 (Published online 2 June 2009); Peter J. Cunningham, [“The Growing Financial Burden of Health Care: National and State Trends, 2001–2006,”](#) *Health Affairs* Web First, March 25, 2010; Michelle M. Doty, Ph.D., Sara R. Collins, Ph.D., Sheila D. Rustgi, and Jennifer L. Kriss, [Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families](#) (Commonwealth Fund, August 20, 2008) ; and Hewitt Associates, [“Cost Reduction and Engagement Survey”](#) (April 2009).
³ See Gould, [Decline in employer-sponsored health coverage accelerated three times as fast in 2009](#); Kaiser Family Foundation, [“The Uninsured: A Primer \(Supplemental Data Tables\)”](#) (October 2009); Sara R. Collins, Jennifer L. Kriss, Michelle M. Doty, and Sheila D. Rustig, [“Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families—Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007](#) (August 20, 2008); John Holahan and A. Bowen Garrett, [“Rising Unemployment, Medicaid and the Uninsured,”](#) (Kaiser Family Foundation, 2009).

⁴ On underinsurance, see D. Blumenthal, [“Employer-sponsored health insurance in the United States--origins and implications,”](#) *N. Engl. J. Med.*, July 6, 2006; 355(1): 82–88; Kaiser Family Foundation, [“Survey of People Who Purchase Their Own Insurance”](#) (June 2010); C. Schoen, [Insurance Design Matters: Underinsured Trends, Health and Financial Risks, and Principles for Reform](#), Hearing on "Addressing the Underinsured in National Health Reform," U.S. Senate Health, Education, Labor and Pensions Committee, February 24, 2009.

⁵ See Karen Davis, [A New Era in American Health Care: Realizing the Potential of Reform](#) (The Commonwealth Fund, June 2010). On the challenges of implementation, see Paul Starr, [The Next Health Reform Campaign](#), *The American Prospect* (16 August 2010).

⁶ [Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage](#), United States General Accounting Office, GAO-04-312 (February 2004) 2-3; [“Health Care-Related Scams Follow Passage of Overhaul Bill,”](#) *Dayton Daily News* (5 June 2010); Alison Young, [“States Fret over Insurance Scams,”](#) *USA Today* April 12, 2010; [“Health Insurance Scams Still Flourishing”](#) Austin Better Business Bureau (May 2010).

⁷ Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#) (November 18, 2004), 8; [In the Matter of The Capella Group dba Care Entree](#), CA Department of Managed Health Care Cease and Desist Order (Sept. 2006).

⁸ Jon Gabel et al, “The Emergence and Future of PPOs,” *Journal of Health Politics, Policy and Law* 11:2 (1986), 306-7

⁹ [Multiplan](#) was founded in 1980. It acquired a number of regional PPOs between 1997 and 2004, and then acquired Private Healthcare Systems, an early industry giant, in the late 2006. [Beech Street](#) acquisitions include HealthCare Preferred (2004), Univera (2004), BestCare (2005), PPONext (2007), Texas True Choice (2007). See also the corporate profiles for [Three Rivers](#), and [Galaxy Health](#); and Robert Lowes, “Caveat doctor! Medical discount cards could burn you,” *Medical Economics* (Feb 19, 2001).

¹⁰ Precis Inc, SEC 10-Q (September 20, 2006). See also [In the Matter of The Capella Group dba Care Entree](#) CA Department of Managed Health Care Cease and Desist Order (Sept. 2006), and Access Plans USA, [Annual Report](#) for fiscal 2007.

¹¹ The terms and costs of plans are based on a July 2010 survey of leading discount medical plans. Plans were identified through internet searches, and the lists of registered or licensed DMPOs maintained by state insurance commissions. This yielded a database of 75 discount medical plans.

¹² Florida CVS Stores Now To Carry Blue Cross and Blue Shield of Florida Health Cards , *Drug Week* December 4, 2009; Mila Kofman, Jennifer Libster, Elisa Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), Report to the State of Florida, Office of Insurance Regulation (November 2006), 20

¹³ See Patriot Health of Florida, Annual Report to the State of West Virginia (2010), public records request in possession of author.

¹⁴ Access Plans USA, [Annual Report](#) for fiscal 2007. A company’s mix of retail and wholesale plans can also be suggested by its revenue/member (in states reporting this data). In Florida, for example, registered DMPOs with the largest member base also reported the lowest revenue per member—suggesting a reliance, by the larger forms, on rebranded and wholesale lines.

¹⁵ CHA Board Members include Careington, Coverdell, New Benefits, and Optum Health Allies. Other members include Aegon, Alliance, Cinergy, and Vantage.

- ¹⁶ Indiana Department of Insurance, Annual Reports (DMPO-AR-R/10-08) for Fiscal Year ending December 31, 2009, on file with author.
- ¹⁷ Florida Office of Insurance Regulation, Annual Reports (OIR-A1-1671) for Fiscal Year ending December 31, 2009, on file with author.
- ¹⁸ “[In the Matter of Elite Health Care, Republic Health Care, Easy Life Health care, Global Health Care and Michael J. Ellman](#)” CA Department of Managed Health Care Cease and Desist Order (Feb. 2010), online at; see websites for [Health Care One](#), [Republic Health Care](#), [Elite Health Care](#), and [Easy Life Health Care](#); Alliance Health Card, [Annual Report for Fiscal 2008](#) (Edgar Online).
- ¹⁹ Galaxy Health Network Discount Card Clients and Programs (July 2009), available at www.galaxyhealth.net/pdf/msc_clients.pdf; for the logo product offered by Beech Street, see <http://www.beechstreet.com/providers/ProductDescription.html>
- ²⁰ Company claims are from Alliance Health, SEC 10-K (September 20, 2009); Mila Kofman, Jennifer Libster, Eliza Bangit, [Discount Medical Cards: Innovation or Illusion?](#) (Commonwealth Fund, 2005), 3; Family Care Awarded First Multiple Product Discount Medical Plan License in California, Drug Week (July 3, 2009); Duke Helfand, “State targets health plans, Los Angeles Times February 8, 2010; and Access Plans USA, [Annual Report for fiscal 2007](#) (Edgar Online).
- ²¹ For coverage estimates, see <http://consumerhealthalliance.com/site/page/pg3072.html>; Testimony of Vincent DiBenedetto (Best Benefits, Inc), [Florida Consumer Health Alliance DMPO Hearing](#) (2006); Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#); Alliance Health, SEC 10-K (September 20, 2009)
- ²² Indiana Department of Insurance, Annual Reports (DMPO-AR-R/10-08) for Fiscal Year ending December 31, 2009, on file with author; Florida Office of Insurance Regulation, Annual Reports (OIR-A1-1671) for Fiscal Year ending December 31, 2009, on file with author; and West Virginia Insurance Commissioner, Annual Reports (DMPO renewal app) for Fiscal Year ending December 31, 2009, on file with author.
- ²³ Economic data from U.S. Bureau of Labor , [Economy at a Glance Tables](#); demographic data from U.S. Census Bureau, [State and County Quick Facts](#); health coverage from U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement, [Table HI06. Health Insurance Coverage Status by State for All People: 2008](#).
- ²⁴ Joanna Turner , Michel Boudreaux, and Stephanie Lynch, [A Preliminary Evaluation of Health Insurance Coverage in the 2008 American Community Survey](#) (Census Bureau, September 2009); State Health Access Data Assistance Center, [Measuring the Adequacy of Coverage or Underinsurance](#) (SHADAC, January 2004).
- ²⁵ Peter Fisher, Elaine Ditsler, David West, and Colin Gordon, [Nonstandard Jobs, Substandard Benefits](#) (Iowa Policy Project, 2005).
- ²⁶ Examples here drawn from [USA Health Care Savings](#); Access Plans USA, [Annual Report for fiscal 2007](#) (Edgar Online); [Careington Total Care Plan](#); [Just Benefits](#); [My Complete Care](#)
- ²⁷ See, for example, the plans offered by [International Association of Benefits](#) or [National Benefit Advisory Association](#).
- ²⁸ See also Kofman, Libster, and Fisher, “[Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States,](#)” 24.
- ²⁹ Access Plans USA, [Annual Report for fiscal 2007](#) (Edgar Online).
- ³⁰ Mila Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#) 8-9.
- ³¹ See Mila Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#); [Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage](#), United States General Accounting Office, GAO-04-312 (February 2004); Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#); Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#) (November 18, 2004).
- ³² Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 11-14; Laura Gunderson, “Read those medical discount plan offers carefully”, *The Oregonian* (January 3, 2009); Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#), 3; [Canadian Operation That Charges U.S. Consumers Without Authorization Challenged by the FTC](#) (February 2003); [Colorado Insurance Commissioner Orders “Cease and Desist” for Sale of Fraudulent Health Insurance](#) (October 2008).
- ³³ These examples from Alison Young, “[States Fret over Insurance Scams,](#)” *USA Today* April 12, 2010; and Kate Pickert, “[Cheap Health Care Plans: Let the Buyer Beware,](#)” *Time* (26 April, 2010); Colorado Division of Insurance, [Scammers Out to Take Advantage of Health Reform](#) (Oct. 2008).
- ³⁴ Precis Inc, September 2008 Quarterly Report (10-Q), <http://www.sec.gov/Archives/edgar/data/1017440/000095013408020676/d65209e10vq.htm>
- ³⁵ See Colorado Division of Insurance, [In the Matter of National Alliance of Associations](#), DOI Order No. 008120 (2008); Colorado Division of Insurance, [In the Matter of Consolidated Workers Association](#), DOI Order No. 009042, (January 2008); North Carolina Department of Insurance Cease and Desist Order, [In the Matter of Consolidated Workers et al](#), Docket #1421 (Sept. 2009); Alison Young, “[States Fret over Insurance Scams,](#)” *USA Today* April 12, 2010; Better Business Bureau (LA) [review of National Alliance of Benefit Service Associations](#) (accessed July 2010).

- ³⁶ Quoted in Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 6.
- ³⁷ “Notice of Proposed Disciplinary Action [Montana]” (July 2006) and *Ameriplan v Walker* [Dallas County Texas], both reprinted in Ameriplan, Annual Report to the State of West Virginia (2010)
- ³⁸ Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 4
- ³⁹ G. Britton, “Discount Medical Plans and the Consumer: Health Care in a Regulatory Blindspot,” *Loyola Consumer Law Review* 16 (2004): 99-100; Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#) (November 18, 2004), 1-2; Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#) 4; Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage, United States General Accounting Office, GAO-04-312 (February 2004), 4, 12; North Carolina Department of Insurance, [In The Matter Of Affinity Group Benefits Association](#), Docket 1417 (Feb. 2009; Colorado Division of Insurance, [In the Matter of National Alliance of Associations](#), DOI Order No. 008120 (2008)
- ⁴⁰ “[In the Matter of Equal Access Health](#)” CA Department of Managed Health Care Cease and Desist Order (July 2005), online at; Alison Young, “States Fret over Insurance Scams,” *USA Today* April 12, 2010; Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#) 3; Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#), 14-15; Dan Bowman, “Discount Insurance Companies Sued for Exploiting Customers,” *Fierce Healthcare* (February 2010); Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 6-7; Access Plans Inc, SEC 10-Q (March 2010).
- ⁴¹ *Precis Inc*, [September 2008 Quarterly Report](#) 10-Q (Edgar Online); Access Plans USA, [Annual Report for fiscal 2007](#) (Edgar online); “[In the Matter of First Choice Health Care](#)” CA Department of Managed Health Care Cease and Desist Order (April 2006); Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#) 3; Kofman et al, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 7-8.
- ⁴² G. Britton, “Discount Medical Plans and the Consumer,” 106-7.
- ⁴³ “[In the Matter of Equal Access Health](#)” CA Department of Managed Health Care Cease and Desist Order (July 2005); Robert Lowes, “Caveat doctor! Medical discount cards could burn you,” *Medical Economics* (Feb 19, 2001); Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 9-10.
- ⁴⁴ See *Patriot Health of Florida*, Annual Report to the State of West Virginia (2010); *Blackmon et al v Ameriplan v Walker* [Wilcox County Alabama] (May 2009), and ⁴⁴“Notice of Proposed Disciplinary Action” (July 2006) reprinted in Ameriplan, Annual Report to the State of West Virginia (2010). Public records requests in authors possession.
- ⁴⁵ William Andrew Rivell, Alan B. Whitehouse, individually and on behalf of all other persons similarly situated, Plaintiffs-Appellants, versus Private Health Care Systems, d.b.a. Care Entree, The Capella Group., Defendants-Appellees, United States Court of Appeals for the Eleventh Circuit, 520 F.3d 1308; 2008 U.S. App. LEXIS 6089; 86 U.S.P.Q.2D (BNA) 1061; 21 Fla. L. Weekly Fed. C 498, March 2008; Lowes, “Caveat doctor! Medical discount cards could burn you”; Jonathan G. Bethely, “[Aetna to offer discount cards, starting in Denver. New Jersey.](#)” *American Medical News* (August 2006).
- ⁴⁶ Alison Young, “States Fret over Insurance Scams,” *USA Today* April 12, 2010; Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#) 4; WAAY 31 (Huntsville AL) [BBB Says Discount Card May Not Offer Consumers Many Savings](#) (September 2008); Ellen Gabler, “[Medical discount cards might not offer much, or any, savings.](#)” *Milwaukee Journal Sentinel* (Posted: March 12, 2009).
- ⁴⁷ Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#), 14-15; Colorado Division of Insurance, [In the Matter of National Alliance of Associations](#), DOI Order No. 008120 (2008); Plaintiff’s Original Petition, *State of Texas v The Capella Group Inc., dba Care Entrée*;
- ⁴⁸ Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#), 2-3.
- ⁴⁹ Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 8.
- ⁵⁰ [Plaintiff’s Original Petition](#), *State of Texas v The Capella Group Inc., dba Care Entrée*; see also “[In the Matter of Equal Access Health](#)” CA Department of Managed Health Care Cease and Desist Order (July 2005)
- ⁵¹ Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#) 5-6; see also Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 8,
- ⁵² The mean hospital bill at discharge for an uninsured patient is \$22,512 (weighted national estimate from HCUP Nationwide Inpatient Sample (NIS), 2008, [Agency for Healthcare Research and Quality](#) (AHRQ). Average charge for the 5 most common outpatient procedures are hypertension (\$708), chest pain (\$3205), lower back pain (\$1,353), atrial fibrillation (\$1,250), and abdominal pain (\$2315). See [Becker’s Hospital Review](#) (October 2009).
- ⁵³ Kofman, Libster, and Fisher, [Discount Medical Plan Organizations: Past, Present, and Future in Florida and Other States](#), 15.
- ⁵⁴ Kate Pickert, “Cheap Health Care Plans: Let the Buyer Beware,” *Time* (26 April, 2010). For their part, DMPOs have been content to linger in the regulatory shadows. “We receive inquiries from insurance commissioners in various states that require us to supply information about our discount healthcare programs, representatives, etc. to the insurance commissioner or other state regulatory agency,” as one company prospectus observed in 2007, concluding that “[t]o date, these agencies have

concluded with our view that our discount healthcare programs are not a form of insurance. There is no assurance that this situation will not change in the future, and an insurance commissioner will successfully challenge our ability to offer our programs without compliance with state insurance regulation.” See Access Plans USA, [Annual Report for fiscal 2007](#) (Edgar Online).

⁵⁵ CA Department of Managed Care, [Laws Relating to Health Care Plans in California](#) (accessed July 2010); Access Plans USA, [Annual Report for fiscal 2007](#) (Edgar Online).

⁵⁶ Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#), 14-15; G. Britton, “Discount Medical Plans and the Consumer,” 113-115.

⁵⁷ [Georgia Code 10-1-393](#); [Illinois Code 815 505/2B.3](#); [Kansas Code 50-1-101](#); [Kentucky Code 367.828](#)

⁵⁸ See, for example, [Utah Code 31A:8A](#) and [Georgia Code 10-1-393](#).

⁵⁹ [New York State Attorney General’s Advertising, Marketing and Program Guidelines For Medical and Prescription Discount Cards](#) (2008); see also Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#), 6-7; G. Britton, “Discount Medical Plans and the Consumer,” 111-113; and Richard Cauchi, [Health Care Discount Plans: State Roles and Regulation](#), (National Conference of State Legislatures, May 2009).

⁶⁰ Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#) 7.

⁶¹ Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#), 8-9.

⁶² [Florida Code ss. 636.202-636.244](#).

⁶³ This, and the chart following, is based on the author’s July 2010 survey of state codes, building on Cauchi, [Health Care Discount Plans: State Roles and Regulation](#); and “Summary Chart of State Medical and Pharmaceutical Discount Plan Laws and Regulations” (National Association Of Insurance Commissioners, 2004) , reproduced as Exhibit B in Maryland Insurance Commission, [Report of the Maryland Insurance Commissioner Regarding Discount Card Plans](#), 22-30.

⁶⁴ Cauchi, [Health Care Discount Plans: State Roles and Regulation](#); Kofman et al, [Discount Medical Cards: Innovation or Illusion?](#) 8; quote is from [Idaho Code 48-1601](#); see also [Arkansas Code 4-106-201](#).

⁶⁵ [Utah Code 31A:8A](#)

⁶⁶ [Louisiana Code 22:1260](#); see also [Indiana Code 27-17](#); [Maryland Insurance Code 14:6](#); [Florida Code ss. 636.202-636.244](#); [Arkansas Code 4-106-201](#).

⁶⁷ [Alaska Code Sec. 21.36.030](#)

⁶⁸ [South Dakota Code 58.17E](#)

⁶⁹ [Utah Code 31A:8A](#)

⁷⁰ [North Dakota Revised Statutes 26.1-53](#)

⁷¹ [Florida Code ss. 636.202-636.244](#)

⁷² G. Britton, “Discount Medical Plans and the Consumer,” 113-115; Cauchi, [Health Care Discount Plans: State Roles and Regulation](#).

⁷³ [Connecticut Code Sec. 38a-479rr](#)

⁷⁴ See [Florida Code ss. 636.202-636.244](#); [New Hampshire Revised Statutes 37.415.I](#)

⁷⁵ “[Health Insurance Plans Required to Register with Department](#)”, *Illinois Insurance* (April 2004); California Department of Managed Care, [DMHC Licenses First Discount Health Card in California](#) (July 2006).

⁷⁶ See, for example, [Missouri Revised Statutes 376.1504](#); [Nebraska Revised Statute 44-8306](#); [New Hampshire Revised Statutes 37.415-I](#); [Oklahoma Statutes 36.12.1219.4](#); [South Dakota Codified Laws 58-17E](#); [West Virginia Code 33.15E](#).

⁷⁷ See [Connecticut Code Sec. 38a-479rr](#); [Indiana Code 27-17-2](#); [Louisiana Revised Statutes 22:1260.4](#); [Nevada Revised Statutes Ch. 695H](#); [Oregon Revised Statutes 742.422](#) [South Carolina Code 37-17-40](#); [Montana Code 33-38-105](#); [Florida Code ss. 636.202-636.244](#).

⁷⁸ Cauchi, [Health Care Discount Plans: State Roles and Regulation](#); for an example see [Arkansas Code 4-106-201](#).

⁷⁹ See, for example, [Nevada Revised Statutes Ch. 695H](#) or [Missouri Code 376.1500](#).

⁸⁰ [Florida Code ss. 636.202-636.244](#)

⁸¹ [Connecticut Code Sec. 38a-479rr](#)

⁸² See [Florida Code ss. 636.202-636.244](#); [Connecticut Code Sec. 38a-479rr](#); [Ohio Revised Code Ch. 3961](#); [South Dakota Codified Laws 58-17E](#); [Revised Code of Washington 48.155.080](#); [West Virginia Code 33.15E](#)

⁸³ [Texas Insurance Code 21.7001](#)

⁸⁴ [Connecticut Code Sec. 38a-479rr](#)

⁸⁵ See [Florida Code ss. 636.202-636.244](#); [Revised Code of Washington 48.155.110](#); [West Virginia Code 33.15E](#).

⁸⁶ [Indiana Code 27-17-2](#)