2004

Discount Medical Plans and the Consumer: Health Care in a Regulatory Blindspot

Gerard Britton
Assist. Prosecutor, Chief of the Insurance Fraud Unit, Office of the Morris County Prosecutor, Morristown, PA

Follow this and additional works at: http://lawecommons.luc.edu/lclr

Part of the Consumer Protection Law Commons

Recommended Citation
Available at: http://lawecommons.luc.edu/lclr/vol16/iss2/2

This Feature Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in Loyola Consumer Law Review by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.
Discount Medical Plans and the Consumer: Health Care in a Regulatory Blindspot

By Gerard Britton*

"That's right buddy, the large print giveth, and the small print taketh away."¹

I. Introduction

The increasingly high cost of health care coverage has precipitated the emergence of a novel health care coverage product: "the discount medical plan."² Discount medical plans claim to help reduce the cost of medical services to the uninsured by acting as brokers between consumers and a network of contracted providers who will perform medical services at a discounted fee.³ These plans

* Assistant Prosecutor, Chief of the Insurance Fraud Unit, Office of the Morris County Prosecutor, Morristown, New Jersey; J.D., New York Law School, 1990. The author wishes to thank Mila Kofman, J.D., Tyler Chin, American Medical News, and Michael Paiva for their help in finding information for this article.

¹ TOM WAITS, Step Right Up, on Small Change (Elektra/Asylum 1976).

² There are a variety of health related discount plans that are marketed to the consumer. Most offer services that include some or all of the following discounts: prescription; dental care; vision care; and alternative medicine. Moreover, because the discount plan market is new and in flux, some discount medical plans differ from the basic model in the way that they apply discounts and process claims. For purposes of this article a discount medical plan is defined as one that offers to provide access to treatment by a physician and/or a medical facility, such as a clinic or hospital, but does not accept or disburse money for the payment of claims.

are promoted as a viable and affordable alternative for those who cannot afford traditional health care coverage and appear attractive to the uninsured and those who have high-deductible health insurance policies.\(^4\)

Although various plans differ, a common feature of all of these plans is the promise of significant discounts for physicians’ services and hospitalization costs.\(^5\) The plans tout substantial discounts for “in-network” provider services and promise these savings at a slight fraction of the cost of health insurance.\(^6\) The plans do not involve insurance companies; consumers are solely responsible for the payment of their health care bill.\(^7\) The plans are marketed aggressively via Internet websites, email messages, telemarketers, and infomercials.\(^8\) The marketing accompanying these plans mimics that of traditional health plans. The plans have been the subject of criticism on several fronts. For example, the plans are being used as a vehicle for fraudulent enterprises,\(^9\) mislead consumers into believing that the plans represent health insurance coverage,\(^10\) exaggerate the level of discount that consumers actually receive for these services,\(^11\) and present provider lists that are grossly inaccurate.\(^12\)

In response to the proliferation of companies offering these plans and the attendant complaints, advisories have been issued by

\(^4\) Id.


\(^7\) Id.


\(^10\) See Lieberman, supra note 6.

\(^11\) Id.

\(^12\) See, e.g., Susan Lundine, Medical Cards Prompt Call For Inquiry, ORLANDO BUSINESS JOURNAL (Nov. 25, 2002), http://www.bizjournals.com/orlando/stories/2002/11/25/story2.html?jst=s_rs_hl (last visited Aug. 8, 2003); Lowes, supra note 3.
various attorneys general, state consumer protection agencies, insurance departments, and better business bureaus. These groups have alerted consumers of the hazards of these plans. The media has also notified the public of dissatisfied consumers who bought into plans that did not live up to their advertising promises or consumers who were enrolled in a discount medical plan without their approval.


Moreover, the issue of discount medical plan fraud was recently addressed in a Bureau of National Affairs Report, discussing the problem of phony health insurance. In February 2003, Canadian authorities, working with the Federal Trade Commission ("FTC"), brought criminal charges against two discount medical plan companies that had been operating telemarketing "boiler rooms" in Toronto. The companies used high-pressure sales tactics and deceptive practices to swindle consumers. Recently, Hawaii's Better Business Bureau challenged the advertising claims of a major discount plan. And, currently, in California, there is a legislative effort to specifically regulate these plans. At least one civil suit has been filed seeking damages and injunctive relief against a discount plan company in California.

Yet, despite the apparent proliferation of companies offering such plans, the apparent concern of regulators and watchdogs, the anecdotal evidence of consumer deception and fraud, and the potential for increasing abuses, there appears to be little research


See generally Kofman, supra note 9.


See id.


See Marquand, supra note 17.


The current movement to implement some form of government-supported private prescription drug "plans," as laudable as it is, will only increase the avenues by which unscrupulous operators, working in an unregulated market, can don a cloak of legitimacy while defrauding consumers. See Patricia Barry, Prescription
available for consumers on important aspects of the discount medical plan market. Similarly, there is virtually no information available on the level of interest in these plans, the current usage of plans, the level of satisfaction of enrolled consumers, the overall impact of these plans on the uninsured consumers, or the legitimacy of the claims made by the companies offering them.

Moreover, unlike traditional health care plans, discount medical plans do not operate under any state or federal health insurance regulations. Because the plans bear no responsibility for processing or payment of medical claims, they are exempt from the regulatory framework developed in the health insurance market, meant to ensure the integrity of health insurance products and to protect consumers.25

This article first defines the basic elements of discount medical plans and explains the proliferation of companies offering them. The article then explores the issues and problems related to these plans in the context of consumer protection and the current status of state regulation of these plans. Finally, the article advances an argument for more formal study of the impact of these plans on the uninsured consumer and suggests potential consumer protection remedies to prevent abuses inherent in these plans. Ultimately, the article is intended to inspire discussion about how these plans affect consumers and what actions the states and the federal government should take to protect consumers.

II. Discount Medical Plans

In theory, discount medical plans are based upon contractual relationships with providers and offer a price reduction to the consumer. First, a discount medical plan purchases a list of network providers and a discount fee schedule from a Preferred Provider Organization ("PPO").26 A PPO is "a health care financing and delivery program that provides financial incentives to consumers to


26 See Chin, supra note 5.
utilize certain ‘preferred’ providers.²⁷ The PPO also contracts with providers who agree to accept reduced fees in exchange for the promise of a patient base created by the PPO.²⁸ In exchange for an initial fee from the enrolled consumer, the discount medical plan issues a card to the enrolled consumer that ensures the PPO discounted rate for services rendered by the PPO network provider.²⁹

The consumer agrees to a set of conditions for the discount to apply.³⁰ The crucial requirement is that the consumer must pay the discounted cost of service in full at the time of treatment.³¹ The discount medical plan does not make payments or reimbursements.³²

The discount medical plan system is predicated upon a set of interlocking, contractual agreements: discount plan restrictions on the enrolled consumer;³³ agreements between the plan and the PPO;³⁴ and agreements between the PPO and the provider.³⁵

A discount medical plan operating properly within this framework would potentially offer savings to some consumers. For instance, uninsured consumers who could pay for the cost of their medical care would save money.³⁶ Such a consumer, enrolled in a properly performing discount medical plan, would be entitled to the contractually defined discount upon which the PPO and provider agreed.³⁷ However, there have been significant problems associated with the influx of discount medical plans into the health care market. The reasons for this influx, as well as a description of some of the


²⁸ See Classen, *supra* note 27, at 255.

²⁹ The initial fee is typically several hundred dollars, and the monthly payment usually costs between $20 and $90. See Lieberman, *supra* note 6.


³¹ Id.

³² Id.

³³ Id.

³⁴ See Chin, *supra* note 5.

³⁵ See Classen, *supra* note 27.

³⁶ See, e.g., Marquand, *supra* note 17.

³⁷ See Lowes, *supra* note 3.
attendant problems, are discussed in the sections below.

A. The Proliferation of Discount Medical Plans

Four primary factors have contributed to the emergence of discount medical plans: (1) consumer expectations; (2) the rising cost of traditional health care coverage and the emergence of PPOs; (3) the complexity of the health care system combined with consumer assumptions about traditional protections; and (4) the gap in regulatory oversight in the health care field resulting from the existence of PPO contracts. These factors are further discussed below.

1. Expectation vs. Cost

Among its other maladies the American health care system suffers from schizophrenia. Americans believe that quality coverage should be a basic right available to everyone. This belief is most likely based on the realization, and a correct one, that insurance coverage is the *sine qua non* of access to adequate medical treatment. However, while the public acknowledges the basic need for coverage and believes that it should be almost concomitant with citizenship, the reality is that many Americans actually have little access to adequate health coverage. In 2002 over 43 million people

---

38 See Kaiser Family Foundation, Newshour Uninsured Survey (Jan. 2000), http://www.kff.org/healthpollreport/templates/reference.php?page=6_2000_01&feature=feature3 (last visited Aug. 8, 2003). In this survey the Kaiser Family Foundation (“KFF”) asked whether respondents agreed or disagreed that health care should be provided equally to everyone, just as public education is. KFF posted the following results of the survey:

- Agree Strongly – 62%
- Agree Somewhat – 22%
- Disagree Somewhat – 8%
- Disagree Strongly – 7%
- Don’t Know – 1%


40 The U.S. Census Bureau estimates that 43.6 million Americans were uninsured for the entire year, an increase of 2.4 million people over the previous year. See U.S. Census Bureau, Health Insurance Coverage 2002 Highlights,
under the age of 65 had no health insurance.\textsuperscript{41} The cause is clear: expense.\textsuperscript{42} The cost of premiums for employer-sponsored health insurance rose almost 14 percent between the spring of 2002 and the spring of 2003.\textsuperscript{43} These increased costs are borne by both the employer and employee.\textsuperscript{44}

Moreover, those seeking individual insurance policies face prohibitive premiums and significant burdens concerning access to insurance.\textsuperscript{45} The resulting picture is somewhat grim. Those without coverage must obviously make do without health care or struggle financially to obtain it. On the other hand, those fortunate enough to be in an employer-based plan find their rates escalating at an alarming pace.\textsuperscript{46} In either case consumers incur significant costs to obtain access to health insurance. Increased costs are driving many people into the precarious situation of foregoing insurance altogether and risking financial calamity in the event of serious illness.

\section{The Rising Costs of Health Care and the PPO}

During the 1990s, spiraling costs led to the emergence of the Health Maintenance Organization ("HMO").\textsuperscript{47} Although HMOs were designed to constrain costs, the attendant restrictions they imposed on consumers led to the development of a new managed health care model: the PPO.\textsuperscript{48} PPOs gained favor in the early 1990s because they

\begin{itemize}
\item [\textsuperscript{41}] http://www.census.gov/hhes/hlthin02/hlth02asc.html (last visited Sept. 30, 2003).
\item [\textsuperscript{42}] \textit{Id.}
\item [\textsuperscript{43}] \textit{Id.}
\item [\textsuperscript{44}] \textit{Id.}
\item [\textsuperscript{46}] \textit{See} Kaiser 2003 Employer Health Benefits Summary, \textit{supra} note 42.
\item [\textsuperscript{48}] \textit{See} Classen, \textit{supra} note 27.
\end{itemize}
promised a managed care system more flexible than the HMO.\footnote{See Lieberman, supra note 6.} Unlike many HMO models that restrict access by consumers to network providers and use a fixed payment-per-patient system, PPOs allow patients to go outside the network of providers and do not impose a flat reimbursement rate to providers.\footnote{Id.} PPO agreements are based upon a contract between the PPO and the provider that provides, in part, the schedule of payment for specified medical services.\footnote{See Classen, supra note 27, at 255.} Separately, the PPO and the payor each enter into a contract with the third-party payor, which is typically an insurance company or employer.\footnote{Id.}

The benefits of the PPO system to the provider are a larger patient base and the assurance of payment by the payor, typically an employer, a union, or a health insurance company.\footnote{Id.} In exchange the PPO network provider agrees to provide services to PPO members at a discounted rate.\footnote{Id.}

There are also benefits to the patient. The patient has a large provider list from which to choose and retains the ability to go outside the PPO network, although at a higher cost.\footnote{Id.} Under a PPO plan the patient has to provide a co-payment as additional cost control.\footnote{Id.} In 2000 revenues from PPOs accounted for 26 percent of gross income for family practitioners.\footnote{Id.}

The contractual cracks in this system through which the discount medical plan industry grew involve the definitional ambiguity of many contracts between PPOs and providers. First, providers normally agree in contracts with a PPO to allow the PPO to

\footnote{A co-payment, or co-insurance, is a portion of the bill for a medical service that is not covered by the health insurance policy and must be paid by the patient.}

\footnote{See Ken Terry, Survey Report, Managed Care: Could You Live Without it, MEDICAL ECONOMICS (Dec. 3, 2001), http://www.memag.com/be_core/search/show_article_search.jsp?searchurl=/be_core/content/journals/m/data/2001/1203/w2_1emancare.html&title=Survey+Report++Managed+care%3A+Could+you+live+without+it%3F&navtype=m&amp;query=managed+care+terry (last visited Aug. 1, 2003).}
sell access to the “payors.” In older contracts the term “payor,” the entity that would pay the bulk of the bill for services rendered, was either ill-defined or not defined at all. The prevailing assumption implicit in these agreements was that the “payor” would be a third-party payor. Self-paying patients represent a risk that physicians do not contemplate when contracting with a PPO. Second, these contracts often did not limit the PPOs right to sell or lease these provider lists. Because many older contracts did not define the term “payor,” its scope was open to interpretation. Consequently, a cottage industry developed. Third-party “brokers” emerged and, unbeknownst to providers, bought or leased schedules and provider lists from PPOs or other brokers. These brokers then began offering discount health care services to end-users directly.

3. Health Care System Complexity and Consumer Assumptions

Along with the greater costs of health care, decisions about health care coverage are increasingly borne by the consumer. In addition to being uninsured, those who find themselves without health care coverage because they are either unemployed or employed at a job that provides no health care benefits are faced with securing coverage within a system about which they lack knowledge. Some workers, although eligible for insurance coverage through some form of employer-based group coverage, often face increased costs in the form of employee contributions to premium

---

58 See Lowes, supra note 3.
59 Id.
60 Id.
61 Id.
62 See Chin, supra note 5.
63 See Lowes, supra note 3.
64 Id.
65 Id.
payment, increased deductibles, and a co-payment schedule.  

Traditionally, consumers' health care choices have involved a straightforward analysis of plan cost versus coverage. However, during the last two decades, with the waxing of insurance costs, waning of insurance indemnity programs, and proliferation of managed care models, employees have been forced to exercise more thought about their health care coverage. Unfortunately, consumers lacked the knowledge to rationally evaluate the merits of various health care plans.

Still, under the traditional framework of statutory protections, ill-informed consumers enjoyed a certain degree of protection. For the most part, consumers did not have to consider the methodology of the payment system to the provider because the regulatory framework operated to insure basic stability and predictability for the consumer. All consumers who sought health insurance received basic protections because virtually all commercial health insurance plans were regulated by the state agencies. Each state maintained an agency to act as the watchdog over the administration of health care plans.

Nevertheless, the traditional fee-for-service health care model left consumers unprepared for and uneducated about the health care choices facing them. This has been illustrated by studies that have examined the issue of consumer familiarity with their health care benefits. The fact is that many insured consumers have little understanding of their own health benefit plan or of the various types of health plans that now exist. The average consumer is not prepared to make competent decisions in an unregulated market.

The lack of affordable coverage has forced consumers to confront a complex health care market, without the benefit of

---

67 See Kaiser 2003 Employer Health Benefits Summary, supra note 42.
68 See Housman, supra note 66.
69 Id.
70 Id.
71 See Kinney, supra note 25, at 358-62.
72 Id.
73 Id. at 358-59.
74 Id.
75 Kinney, supra note 25.
76 See Housman, supra note 66, at 2-3.
experience, training, or information.\textsuperscript{77} Moreover, the assumptions embedded in the traditional, regulated health care market have made consumers particularly vulnerable to bad decision-making when confronted with a new unregulated market.\textsuperscript{78}

4. The Gap in Regulatory Protection

The array of state and federal legislation and rules that regulate the health care system are constrained by their definitional framework. State health plan and insurance watchdogs have consistently found that, because discount medical plans do not bear any financial responsibility for payment or processing of claims, they are not a form of insurance coverage and therefore are not subject to regulation.\textsuperscript{79} Because discount medical plans are not regulated in the same way as health insurance products, they avoid the cost and structural restrictions attendant with compliance, as well as the scrutiny of insurance regulators.\textsuperscript{80} This is a significant incentive for legitimate entrepreneurs and unscrupulous operators to create discount medical plans.

B. Problems Associated with Discount Medical Plans

The reasons given above for the proliferation of discount medical plans reflect, to a certain extent, the problems that have arisen with them. The summary below describes the more prominent issues associated with discount medical plans: benefit uncertainty; deception and fraud; and the lack of regulatory oversight.

1. Uncertainty of Benefits due to Contractual Ambiguity

There have been fundamental questions raised about the basic value of even legitimate discount plans.\textsuperscript{81} For example, does the

\footnotesize{\textsuperscript{77} Id.}

\footnotesize{\textsuperscript{78} Telephone Interview with Mila Kofman, Assistant Research Professor, Georgetown University Institute for Health Care Research and Policy (Dec. 22, 2003).}

\footnotesize{\textsuperscript{79} See Colorado Division of Insurance & Attorney General Publication, \textit{supra} note 15.}

\footnotesize{\textsuperscript{80} See \textit{infra} Part.II.B.3 (observing that discount medical plan complaints are currently handled by the consumer protection units of the state attorneys general).}

\footnotesize{\textsuperscript{81} See Chin, \textit{supra} note 5.}
consumer get anything in exchange for the cost of the plan? Often, because providers are ignorant of their putative association with the plans as “network providers,” their health providers either refuse to honor the cards presented by enrollees or misconstrue them to be a type of third-party payor plan. In those cases providers are forced to submit bills to patients and contend with the very type of billing problems providers expected to avoid. Perhaps, discount card holders would do as well without the plan by negotiating a discount directly with the provider prior to service. Without the existence of direct contractual arrangements between brokers and providers acting as the foundation for discount plans, the discount medical plan industry is unlikely to ever appear completely legitimate.

2. Marketing Deceptions and Fraud

Discount medical plan marketing often mimics the look and feel of traditional health care plan marketing. However, discount medical plans are not insurance or a managed health care product. Although many plans indicate that they are not insurance, such a disclaimer may be couched in phrases that suggest that the plan is superior to insurance. For example, the plan may proclaim that it is not insurance, but rather “a health care savings program that provides access to the medical services all Americans need and deserve.” Or, the plan may advertise that, although it is not health insurance, it is “an innovative new approach to health care.” To an ill-informed consumer these claims may well appear reasonable. Anecdotal evidence, demonstrating that consumers as well as providers mistakenly treat the plans as a form of a third-party payor arrangement, lends credence to this notion. The limitations of these discount plans may only become apparent when a consumer is faced

82 Id. at 23.
83 See Lowes, supra note 3.
84 Id.
85 Chin, supra note 5.
86 Lieberman, supra note 6.
87 Lundine, supra note 12.
88 Id.
89 See Lowes, supra note 3.
with a serious need for medical services.  

A more fundamental question is whether disclaimers effectively inform the average consumer.  

A disclaimer does not inform the consumer of the impact of canceling an insurance policy or deciding to forego the cost of an insurance plan and opting for a discount plan—the effect of a coverage lapse on insurability, portability, and pre-existing conditions, for example. A simple statement that a product is not insurance most likely appears to the average consumer to be more of an informational bite, perhaps even more of a commercial claim, than an effective warning. 

Another problem with discount medical plans involves exaggerated claims of discounts. This practice has led to action by attorneys general in some states. For example, the Iowa Attorney General’s Office sued one plan for the exaggeration of claims of savings, and the plan ultimately issued refunds to consumers. 

Similarly, many plans prominently claim access to “network provider” lists, but providers are often unaware that they are listed and are not willing to accept the cards when presented. Consumers often learn of a provider’s ignorance about the plan and unwillingness to accept the plan card only when medical services are needed. These examples help explain the skepticism expressed by many observers of this market. An entire health care benefit industry that promises discounts from providers, who are unaware of the existence of these types of plans, surprised to be listed by a plan as affiliated providers, and not willing to honor the discounts promised, should draw consumer suspicion. 

These exaggerations are all made in the plan’s marketing pitch, whether by Internet ad, telephone, e-mail or “infomercial.”

---

90 See Lieberman, supra note 6.  
91 See Wary of Health Discount Cards, supra note 16.  
92 Id.  
94 See Wary of Health Discount Cards, supra note 16.  
95 See, e.g., Iowa Attorney General Advisory, supra note 13.  
96 See Lieberman, supra note 6.  
97 See supra notes 8-12.  
98 Lundine, supra note 12.
The existence of foreign-based discount medical plan scams reinforces the skepticism surrounding these marketing campaigns.\(^9\) Indeed, the two largest discount medical plan scams uncovered so far originated in Toronto.\(^{10}\) In those cases fraudsters, Global Discount Healthcare Benefits ("Global") and Med Plan, opened boiler room operations in Toronto and, under the disguise of offering discount medical plans, signed up people who had only requested information, gathered identifying information on thousands of people, and deducted assets from their accounts.\(^{101}\) The ability to operate within the United States without any legitimate commercial presence or licensing requirement only facilitates fraud by telemarketers in this critical consumer service.\(^{102}\)

3. Regulatory Vacuum

State regulatory agencies have consistently demurred when confronted with discount medical plan problems and complaints.\(^{103}\) Discount medical plans do not fall within the definition of the type of plans that are regulated by those agencies.\(^{104}\) The critical features that distinguish the discount medical plan from its regulated cousins are the absence in discount medical plans of the responsibility for both

---


\(^{101}\) Id.


\(^{103}\) See generally supra note 15.

\(^{104}\) Because discount medical plans bear no financial responsibility for payment of services, insurance regulators maintain that the plans are not within their jurisdiction. See, e.g., Daniel Zingale, Director's Opinion 01/1, California Department of Managed Care (issued June 7, 2001), available at http://www.hmohelp.ca.gov/library/regulations/discount/director.pdf (last visited Oct. 6, 2003) [hereinafter California Department of Managed Care Director's Opinion]. Director Zingale's opinion effectively deregulated the discount medical plan market in California, which had been regulated under the Knox-Keene Act. See generally CAL. HEALTH & SAFETY CODE §§ 1340-1345 (2003).
making or processing the payment of claims. Similarly, discount plans fall between the cracks of federal regulation. By dealing directly with the consumer as a mere discounter, plan brokers avoid the regulatory oversight common to the traditional health care market.

Consequently, consumer complaints in regard to discount medical plans are generally handled by the attorney general’s office of each state as part of its function to protect consumers. State consumer protection units field complaints from a large number of consumers and address a wide array of problems. Moreover, agencies that do monitor consumer complaints derive their authority from the pertinent statute or regulation that addresses consumer protection. Although all states have laws that sanction deceptive advertising in the form of exaggerated claims, many states have no law that expressly regulates the form or practice of these discount plans. As discussed in the next section, the scope of regulation varies greatly in the states that do regulate discount plans.

III. Current State Regulations

The emerging quilt of state regulation in the area of discount medical plans has focused on several key aspects: (1) notice to the consumer that the plan is not insurance; (2) contract provisions between the provider and the plan; (3) deceptive practices by the plan; (4) origin of services requirements for the plan; and (5) surety

---

105 See California Department of Managed Care Director’s Opinion, supra note 104.

106 See, e.g., Wary of Health Discount Cards, supra note 16.

107 State advisories about discount medical plans direct complaints to their attorney general’s office. See Colorado Division of Insurance & Attorney General Publication, supra note 15.

108 For example, the Bureau of Consumer Frauds of the Office of the New York State Attorney General fields complaints that include: advertising; auto sales; charities; computers and the Internet; credit and lending; furniture delivery; health; housing; identity theft; investing; and telecommunications issues. See Office of the New York State Attorney General, Consumer Issues, at http://www.oag.state.ny.us/consumer/consumer_issues.html (last visited Oct. 26, 2003) [hereinafter New York Attorney General Consumer Issues].

requirements imposed on the plan.

Nine states require discount plan companies operating within their borders to display a notice on their discount cards indicating that the plan is not insurance: Arkansas; 110 Georgia; 111 Idaho; 112 Illinois; 113 Kansas; 114 Oklahoma; 115 Tennessee; 116 Texas; 117 and Utah. 118 These statutes address the concern that consumers often mistake discount medical plans to be a form of third-party insurance. 119 In addition Utah requires that all ads and materials contain a disclaimer advising the consumer that the plan maintains no liability for guaranteeing providers or the quality of services received. 120

Eight states require that discount medical plans be authorized by a separate contract with the provider: Arkansas; 121 Georgia; 122 Idaho; 123 Illinois; 124 Kansas; 125 Oklahoma; 126 Tennessee; 127 and Texas. 128 These provisions address the concern that providers are unaware of their participation in the plan and are perhaps unwilling to

119 See generally supra notes 110-118.
120 UTAH INS. REG. R590-152-4(E)(3) (effective July 16, 2003).
121 ARK. STAT. ANN. § 4-106-201(2) (2003).
124 ILL. COMP. STAT. 505/2B.3(2) (2003).
honor any discount that the plan promises.\textsuperscript{129} None of these statutes, however, define what constitutes a separate contract. Therefore, it is unclear whether a set of contracts among PPOs, discount medical plans, brokers, and consumers satisfies this requirement.

Five states have laws that specifically define and prohibit deceptive practices by discount medical plans: Idaho;\textsuperscript{130} Illinois;\textsuperscript{131} Kansas;\textsuperscript{132} Oklahoma;\textsuperscript{133} Tennessee;\textsuperscript{134} and Texas.\textsuperscript{135} Nonetheless, the statutes are silent as to the proper agency to conduct the investigation and prosecution of violations under these provisions. Perhaps, the offices of the state attorneys general would handle violations under these statutes.

Some states have imposed residency or bond requirements on discount plan companies to assure that consumers have some form of meaningful redress in case of loss.\textsuperscript{136} Georgia, for example, requires discount companies to accurately state the location of the “source” of the discount medical plan and to refrain from misleading the public as to the location of the business,\textsuperscript{137} and Kansas requires that discount plans obtain and file surety bonds with the Secretary of State.\textsuperscript{138} Additionally, Kansas requires plans to provide, in some circumstances, a right to cancel a discount medical plan contract.\textsuperscript{139} Despite these differences, sanctions for violations of these statutes are consistent. State statutes generally mandate a minimum $10,000 fine for violations, damages, and other court-imposed relief, which could presumably restrict further operations.\textsuperscript{140}

No state currently requires any licensing or certification as a

\textsuperscript{129} See generally supra notes 121-128.

\textsuperscript{130} IDAHO CODE § 48-1601(3) (2003).

\textsuperscript{131} ILL. COMP. STAT. 505/2B.3(3) (2003).

\textsuperscript{132} KAN. STAT. ANN. § 50-1,101(a), (b)(3) (2002).

\textsuperscript{133} OKLA. STAT. § 1219.4(B)(3) (2002).

\textsuperscript{134} TENN. CODE ANN. § 47-18-2701(3) (2003).

\textsuperscript{135} TEX. BUS. & COM. CODE ANN. § 17.46(b)(18)(C) (2003).


\textsuperscript{137} GA. CODE ANN. § 10-1-393(4)(A) (2003).


\textsuperscript{140} See, e.g., OKLA. STAT. § 1219.4(C) (2002).
prerequisite to companies or agents offering discount plans. Unlike traditional insurance, anyone can contract with a discount medical plan provider to promote the plans. Consequently, multi-level marketing schemes often employ layers of marketers between plan enrollees and the plan itself.

Furthermore, current discount medical plan statutes do not address the issue of patient confidentiality. The Health Insurance Portability and Accountability Act ("HIPAA") does not cover discount medical plans. Thus, it is unclear what duties these plans have to secure the confidentiality of any medical information that they maintain, or safeguard the privacy of the personal and account information in their possession.

Finally, as noted above, there is no state law requiring a discount plan to disclose information that might impact potential consumers' decisions to enroll in a discount medical plan. Further, issues such as pre-existing conditions and subsequent insurability are left to the consumer to discern on his or her own.

IV. Discussion Points and Suggested Changes

The impact on consumers of the discount medical plan market is impossible to gauge because there has not yet been any formal research or investigation conducted on the subject. No nationwide data exists on either the number of enrolled people or the number of complaints logged about the plans. No studies have been conducted to determine the percentage of providers listed by plans who are unaware of their "participation" in the network. Moreover, no

---

141 California and Kentucky did require some form of licensing, but both states rescinded the requirement. See California Dept. of Managed Care Director's Opinion, supra note 104; KENT. REV. STAT. §§ 304.38-500, -510, -515 and 304.43-140 (repealed 2002).

142 See Marquand, supra note 17.

143 Id.

144 This concern has been addressed in many of the advisories issued about discount medical plans. See Colorado Division of Insurance & Attorney General Publication, supra note 15.

145 In 2002 California State Senator Jackie Speier introduced a bill that would have, in part, required discount medical plans to advise consumers that the plan's benefits might duplicate existing insurance benefits and that consumers might be eligible for free or reduced-cost government benefits. The bill did not pass. See Marquand, supra note 17.

146 See generally sources cited supra notes 13-15.
comprehensive investigation has been made of the companies that promote these plans or the multi-level marketing schemes that are often employed by the plans. Although there is anecdotal evidence of the concern about the value of discount medical plans, there appears to be no assessment of the value of plans to consumers who have attempted to use physician and related services under these plans.

Research needs to be conducted to determine the present state of affairs and future trends for the discount medical plan market. Given the latest statistics on the ever-increasing cost of health insurance, there is reason to believe that interest in discount plans will also increase. The information gathered, and subsequent analysis, will help determine the level of regulatory safeguards that are warranted.

Consumers also need to better educate themselves about health care benefits, specifically about the risks inherent in choosing a health care plan, particularly when considering a discount medical plan. Unfortunately, as noted above, consumers presently have little in the way of resources, other than their state consumer affairs bureau, to help determine the merits of any competing plans. Unlike the state of affairs in the area of unlicensed health insurance scams, which are illegal per se and can be uncovered by a call to the state insurance department, consumers are truly on their own when contemplating a discount medical plan.

Perhaps, a nationwide consumer awareness campaign is warranted. Presently, news articles, state advisories, and issued consumer alerts have only educated consumers in the most general sense. An effective campaign will need to be based upon reliable information, such as the number of people enrolled in each plan, the percentage of doctors listed by plans who actually honor discount cards, the number of complaints logged against a plan, and the discount realized for common medical services. The FTC should maintain a specific clearinghouse for the anecdotal information from as many sources as possible. Ideally, this clearinghouse would include information on complaints from Canadian and Mexican consumer agencies, individual consumers, and state agencies entrusted with monitoring discount medical plans. A

---

147 For a discussion of the perils lurking in the health care market, see Kofman, supra note 9.


149 Id.

150 For a summary of efforts in this direction, see Press Release, Competition
comprehensive federal monitoring system is necessary to stay ahead of the fraud curve.

Contracts between providers and PPOs should specifically define to whom the PPO may sell provider lists and discount fee schedules. Not only would consumers benefit from clearly defined contract terms, but providers would also benefit because they would then be able to determine who would have access to the PPO discount. Further, they would be able to reliably assess risks and benefits of contracting with a particular PPO.

State agencies should be required to monitor discount medical plans. Although some state agencies have asserted, sometimes with good reason, that they are not empowered to regulate discount medical plans, the need for oversight is becoming increasingly apparent. Consumer protection agencies within the offices of the state attorneys general are required to address a wide spectrum of consumer complaints and cannot be expected to handle regulation of an entire health care market on their own.

Discount medical plan companies should require licenses in each state in which they operate. In most states consumers seeking insurance can contact a state agency to confirm that an insurance company is licensed. Presently, consumers cannot contact an agency to determine the legitimacy of a discount medical plan. Discount medical plan companies should also be liable for conduct of any entity that promotes their plan. These measures would prevent the type of multi-level marketing that breeds fraud.

Moreover, discount medical plans should be required to maintain an actual commercial presence within the United States. The attorneys general of each state, as well as the FTC, should have the authority to enjoin from further operation within its jurisdiction any discount medical plan company that is found to be operating from a foreign country while maintaining a United States "shell" address. This requirement would ensure that any discount medical plan operating in the United States could be effectively brought within the jurisdiction of a state or federal agency for regulation and also within


151 See, e.g., California Dept. of Managed Care Director's Opinion, supra note 104.

152 See New York Attorney General Consumer Issues, supra note 108.

153 See Kinney, supra note 25, at 358.
the reach of civil litigants for redress of complaints.

Discount medical plan companies should also be required to file a description of the terms of the plans and the benefits promoted, including published rate schedules for treatments. Without some provision for establishing what discounts will be provided, unscrupulous providers and plans could simply claim to offer a discount to plan enrollees without actually providing consumers with any reduction in price.

Furthermore, discount medical plan companies should be required to provide all enrollees with a written summary of plan benefits, costs, and provisions. All plans should be required to explain the possible consequences of opting for a discount plan in lieu of health insurance. Enrollees should be guaranteed a time period within which they can back out of a plan without penalty. Without such a window, consumers might be forced to forego costly “activation fees” in order to back out of a plan.

Finally, state statutes that address discount medical plan requirements should clarify that “separate contracts” means direct contracts between any company, its agents, as well as any independent broker selling discount plans, and the provider who is listed as an in-network member.

V. Conclusion

The cost crisis existing in the health care industry has exposed a significant percentage of the population to the uncertainties of assessing and contracting for health care coverage without the assurance of governmental safeguards. Some consumers have been left to confront an unregulated marketplace in their quest for one of their most critical needs: health care.154 Given this reality, the threats posed by the discount medical plan industry should not be trivialized. True health care coverage will become more unaffordable, and more consumers will be increasingly desperate to reduce these costs. Moreover, discount plans will become more sophisticated in their marketing approaches and will lure more consumers into their plans. The practices, value, and impact of the discount medical plan market are currently unclear. Thorough examination is warranted.

What is clear is that caveat emptor is not a sufficient response to discount medical plans. Health care is too important. Consumers

154 See Jeffrey Hines, Telemarketing Fraud upon the Elderly: Minimizing its Effects Through Legislation, Law Enforcement and Education, 12 ALB. L.J. SCI. & TECH. 839 (2002); see also Kofman, supra note 9.
deserve the type of safeguards that are in place in the consumer insurance arena. A concrete example of some of the most severe abuses observed in the unregulated and unmonitored discount medical plan market might serve to illustrate the potential hazards. Author Barry Dennison related his experience as an unwitting telemarketer inside the Toronto-based Global, one of the fraudulent companies that targeted American consumers. In February 2003 Canadian authorities raided Global’s headquarters. In the article Dennison shed light on some of the dangers presented by an unregulated health care market:

Staff were given lists of banks and credit unions in each state, including route and branch numbers. So if the respondent mentioned a bank’s name, the telemarketer could easily match the name/address of the bank in their city. This gave the impression that Global Healthcare already had the account and that the respondent just had to verify the rest of the number.

I observed that once the front-line telemarketer got the bank account number, a supervisor would take over the phone call to re-confirm all of the consumer’s information—on tape. I described all this in my affidavit—how we were encouraged to get a rhythm going with the caller, saying “yes” to all their personal information so they wouldn’t listen and would automatically agree to an “activation fee.” Often the customer didn’t understand that the activation fee was actually $359 being taken out of their account.

Curious about whether my skepticism had any basis, I began an Internet search. I hadn’t yet scored a sale, and when I discovered sites full of consumers complaining that they didn’t know they’d authorized the removal of money from their account, I was pleased with my poor sales record.155

Consumers in need of vital health care services simply deserve to be protected from this type of predatory conduct.