

November 2006

Report to the State of Florida, Office of Insurance Regulation

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## **DISCOUNT MEDICAL PLAN ORGANIZATIONS:**

**PAST, PRESENT, AND FUTURE IN  
FLORIDA AND IN OTHER STATES**

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## EXECUTIVE SUMMARY

Many uninsured and under-insured Americans are relying on discount medical card programs to access medical care and services at reduced prices. These programs may include discounts for a variety of health care services including vision, dental, prescription drugs and supplies, hospital and/or physician services and care. To access discounts, a consumer pays a monthly fee (and typically a one-time enrollment fee) to a discount card company (in Florida called Discount Medical Plan Organization or DMPO).

Discount medical card programs are not insurance. That means the patient, not an insurance company, is responsible for paying the entire medical bill. Discount card programs allow members to receive a discount on a retail fee charged by a participating doctor, hospital, or other provider.

Discount medical cards have become prevalent across the country as an alternative or a supplement to health insurance. Generally, consumers who cannot afford to buy health insurance, people with medical conditions for whom there are no private health insurance options, older populations, and immigrants buy discount medical cards. Some large employers also offer discount cards to workers who may not qualify for health benefits, and some small businesses have dropped health insurance for discount cards. Additionally, with the growth of consumer-driven health insurance products, some see discount cards as a way to give patients access to discounts when their health insurance plan does not provide for it. (Consumer-driven health plans with provider networks, e.g., PPOs, Blues plans, and HMOs, however, provide their enrollees with access to negotiated provider rates even through they have not yet met their annual deductibles.) Also, some consumers may negotiate with their physicians or other providers a discounted “cash” rate without a discount card.

With their growth in the marketplace and no or limited regulation, there have been widespread fraud and abuse problems reported by consumers and found by state and federal investigators nationwide. In particular, as states have cracked down on health insurance scams, investigators reported that some of the operators of those scams were getting into the discount card business. Phony discount cards have contributed to consumers becoming victims of fraud and abuse. These nationwide problems have affected many Florida residents. In 2003, Florida’s insurance regulators received nearly 1000 consumer complaints related to discount medical cards, many of which were phony cards.

In addition to outright fraud, the following are some of the most common problems:

- Consumers believe or are told they are buying health insurance. The use of insurance “buzz words” such as “coverage,” high prices for some cards, and the sale of cards in a package with insurance and other products (called “bundling”) have contributed to this problem.
- Discounts are smaller than promised.
- Few or no participating providers where a cardholder lives.
- Problems canceling enrollment and unauthorized bank withdrawals and credit card charges.

Of these problems, a consumer’s erroneous belief that discount cards provide traditional health insurance coverage and difficulties in canceling a card have the most significant implications for consumers. Replacing health insurance with a discount card (due to a false believe it is health insurance or without a full understanding of this product), can have life-long implications. For instance, without continuous health insurance, a consumer may become “uninsurable” for life in the individual health insurance market, pay higher premiums, and/or not have their existing medical conditions covered once they are again enrolled in health insurance. This means a consumer will face significant financial and medical consequences as a result of switching from existing health insurance to a discount medical card.

With respect to the second problem, unauthorized charges and bank account withdrawals may mean that moderate income wage earners, or retired people living on fixed incomes, will see their

finances stretched even further. In addition to overdraft bank charges, the potential harm can include adverse effects from not being able to pay rent, buy food or medicine, etc.

As a result of these and other problems, consumers who have become victims of fraud and misrepresentation may never be made whole. For other consumers, buying a product that does not deliver on its promised discounts is also a problem. Consequently, enabling regulators to prevent problems from occurring in the first place is a primary and fundamental task for public policymakers seeking to protect consumers from harm. Some state attorneys general and insurance departments have aggressively pursued discount card fraud and abuse. However, absent laws directed at discount medical cards, it has been difficult.

Florida's policymakers in 2004 passed legislation authorizing insurance regulators to have oversight authority over discount medical plan organizations (DMPOs) and to set standards for discount card products. This legislation at the time was the strongest in the nation and has helped to address fraud and abuse in this market and thus provided much needed protections for consumers. It has also served as a model for new laws in other states including Montana, Nevada, and Utah. The National Association of Insurance Commissioners (NAIC) – an organization whose members are the nation's insurance regulators developing model insurance laws for states -- also based its recently adopted model law (passed unanimously in September of 2006) on Florida's regulatory approach (using Florida's law as the optional, comprehensive standard for consumer protection).

**Florida Law.** Among its most important consumer protections are standards for companies and qualifications for their management to be trustworthy and competent to run the organization (individuals with a history of corrupt or illegal business practices do not qualify).

Standards for products are important to ensure that consumers of those products are protected. Discount cards are based on promises to purchasers, promises that cannot be tested until money has been paid by them. Hands-on regulatory oversight is the only way to ensure that promises reflect actual benefits. To this end, Florida's policymakers provided insurance regulators with the necessary authority – through form and rate filings and market conduct examinations – to ensure that consumers are adequately protected and promises to them are kept. As a result, regulators have been able to address and prevent the types of problems that were prevalent in Florida prior to the law and are still on-going in other states. This has been accomplished in Florida by regulatory review of products and prices before cards are sold to consumers and through market conduct examinations. These oversight tools help prevent problems before consumers are injured, which is important because, as noted above, once a problem occurs it is not always possible to correct it in a way to make the injured consumer whole, especially if a person becomes uninsurable.

The Florida Office of Insurance Regulation (OIR) has taken a number of steps to ensure successful implementation of the new law and to create opportunities for companies to participate in Florida's newly regulated market. These steps included workshops and guides for the regulated community.

The law and regulatory oversight have resulted in a flourishing market. Based on 2005 annual filings, it is estimated that over 1.5 million Florida residents, enrolled in discount card programs, have paid over \$31.5 million for the cards in the first year of operation since implementation of the new law. Also, since implementation, consumer complaints have dropped by 90% with most related to unlicensed DMPOs. Problems with some licensed products, however, continue and areas of concern include cancellation problems and not properly disclosing that the discount card is not insurance.

The response from the regulated community has been mixed. Members of the insurance industry are generally supportive of the law and the oversight activities, while members of the discount card industry urge certain legislative changes. In 2006, Governor Bush vetoed legislation that would have significantly restricted the regulatory authority of OIR. The principal proponent of the 2006 legislation was a trade association representing some of the licensed DMPOs, whose

members sought legislative fixes to statutory requirements they found difficult to comply with and/or not serving public policy goals.

For policymakers one important question is whether state regulation encourages a market for a product that is valuable to individuals and communities while at the same time effectively protecting consumers against documented abuses and fraud by some in the industry. The tradeoffs between regulation and consumer protection are not unique to the discount medical card industry but exist in every industry. The need for effective consumer protection will only grow as more consumers rely on discount medical cards to help them access and pay for necessary medical care and services.

**Recommendations.** To improve protection for Florida's consumers against fraud and abuse and to improve the value of discount medical cards for consumers who rely on these either as a supplement or as an alternative to health insurance, we recommend the following:

**TRANSPARENCY:**

- [ Improve information to help consumers assess a card's value. Access to information on participating providers and prices, after the discount is applied, is important but not currently available.
- [ Disclose the price for the discount medical card to purchasers of "bundled" products. Specific information is necessary to help consumers compare prices.
- [ Improve cancellation policy by requiring full refunds of all fees, including processing and administrative charges.
- [ Develop additional guidance for rates. However, as proposed in 2006, amending the statute to raise the safe harbor for rate approvals from \$30 to \$60 per month means that prices will double. This does not serve the interests of consumers in Florida.

**OVERSIGHT:**

- [ Clarify authority of the OIR over the activities of Florida-based companies selling out-of-state. This will help deter "bad actors" from establishing operations in Florida.
- [ Appoint a contact person for insurance agents, DMPOs, and others in the regulated community to report potentially unlawful activities to OIR. This will encourage reporting of problems by industry. There should also be publicly available information once an OIR investigation is closed. Status information about investigations, e.g., "under investigation" or "investigation closed," will aid consumers and the regulated community.

**MARKETERS AND RESELLERS:**

- [ Clarify that DMPOs may not contract out of their responsibility for acts of their marketers in selling their products. Consider separate licensing for resellers (private label). In the alternative, require DMPOs to provide the OIR with background information on all of their resellers and marketers. This will help address on-going problems related to marketing of discount medical cards.

Finally, we recommend continuing the application of consumer protections to discount medical cards currently subject to the law. On-going problems are not unique to cards for physician and hospital discounts and therefore, exemption from the law for other products, such as dental cards, is currently not justified. We also recommend examining prescription drug cards to assess the need to include those products in existing protections and standards.

**Conclusion.** As more consumers rely on discount medical cards, the need to establish consumer protections and standards for companies and products will also grow. Given the history of abusive practices by some promoters and card issuers that have injured consumers and left some uninsured and uninsurable, as well as on-going problems with licensed companies and products, it is important for policymakers to examine existing standards and find ways to strengthen protections for consumers.

# INTRODUCTION

More and more working Americans are relying on discount medical plans or programs, also called discount medical cards or just discount cards (hereinafter these terms are used interchangeably). Such programs may provide discounts for vision, dental, alternative medicine, prescription drugs and supplies, hospital and/or physician services and care, as well as other medical services. In Florida, it is estimated that over 1.5 million people have discount cards which include cards for dental, vision, prescription drugs/supplies, as well as hospital and physician discount programs.<sup>1</sup> The number of people enrolled in hospital and physician programs is unknown. Some cards may provide discounts solely for a specific service, e.g., vision or dental, while others may include discounts for two or more types of services, e.g., hospital and physician discounts, prescription drugs and supplies, and vision all in one card. Some cards are paired with insurance products such as accident or hospital indemnity insurance.

Discount medical programs are not insurance. Instead they allow members to receive a discounted fee from a participating doctor, hospital, or other provider. The member is responsible for paying providers' fees. There is no insurance company involved that pays for the service. To access a discount, the member must pay an annual or monthly fee, which range from \$100/year to \$300.00/month, and a one time enrollment/administrative fee (usually non-refundable, which can be several hundred dollars).

Discount medical plans have become prevalent across the country – promoted through television and radio advertisements in many markets. Some plans sell through credit cards, banks, and retailers. In addition, some small businesses are offering discount cards to their workers as a replacement for health insurance. Large employers also offer discount cards to workers who may not qualify for health benefits.

Additionally, with the growth of consumer driven insurance products, promoters see discount cards as a way to give people access to discounts when their insurance plan does not. (Consumer driven health insurance plans that have provider networks, e.g., PPOs, Blues plans, and HMOs, however, provide enrollees with access to negotiated provider rates, even through they have not yet met their annual deductibles.)

In this growing market, characterized by limited or no regulation, there have been widespread fraud and abuse problems reported by consumers and found by state and federal civil and criminal investigations across the country. These problems have also affected many consumers in Florida. In fact, in 2003 Florida's insurance regulators received nearly 1000 consumer complaints related to discount medical cards.

Florida's insurance regulators, as well as investigators in the Attorney General's office, have tried to address fraud, misrepresentation, and other problems reported by consumers.

In response to widespread fraud and abuse problems, the Florida state legislature passed a new law establishing a model for regulating discount medical cards. This law establishes standards for companies operating such card programs and consumer protection standards for these products to help prevent problems from arising and to protect consumers when problems do occur.

Part I of this report provides background information about the discount card market – discussing purchasers of this product, the common consumer problems reported to state agencies and found by government investigators, and the fraudulent and abusive practices of some entities in the marketplace. Part II examines how discount medical cards and the companies that issue them are regulated, and the types of consumer protections that exist. Part III examines Florida's approach to protecting consumers of this product and to addressing fraud. Part IV provides an overview of how other states address the regulation of discount medical cards. Part V concludes with recommendations on ways to improve consumer protections in Florida and oversight of discount cards.

# METHODOLOGY

**Background and Methodology:** The Florida Office of Insurance Regulation (OIR) asked a research team at the Georgetown University Health Policy Institute to examine the discount medical card marketplace, the impact of Florida's 2004 legislation in protecting consumers, and to recommend changes to strengthen the regulation, where necessary, and to eliminate any unnecessary components of the current regulatory framework.

This study and the research it contains builds on a Georgetown University study conducted in 2004 and published in 2005. That study focused on cards with discounts for hospital and physician services (copy available at [www.cmf.org/usr\\_doc/808\\_kofman\\_discountmedicalcards\\_ib.pdf](http://www.cmf.org/usr_doc/808_kofman_discountmedicalcards_ib.pdf).) Findings from the 2005 study are referenced in this report where relevant. This current report is not intended to assess the value or benefits that some discount medical programs may offer (see our earlier study for a discussion of one program that offered value and real benefits to a segment of the population). Regardless of how valuable a product may be, regulation is necessary to protect consumers.

For the current study, we researched and analyzed selected state insurance laws, reviewed administrative and civil state and federal government actions, and reviewed recent research literature on this market and products (literature published since the earlier study). With respect to cases filed in state or federal courts, we attempted to contact prosecutors to find out how the court ruled, or if there was a settlement, and included such information when available. We also reviewed advertisements used in 2006, recent news reports, and government consumer alerts. In addition, we interviewed insurance regulators and investigators, prosecutors and other government officials, industry participants, including Florida-licensed companies and other stakeholders. To better understand Florida's marketplace, we also reviewed consumer complaints and form and rate filings submitted to OIR and final reports of market conduct examinations. The public hearing that OIR held in August 2006 also provided useful information from stakeholders.

Part IV of this report includes an in-depth look at selected states that have been aggressive in investigating and taking action against fraud and abuse in the marketplace. The states selected vary in their approaches in regulating discount medical programs – ranging from full licensing to no laws specific to discount medical cards.

We began this research by focusing only on programs that provide discounts for hospital and physician care and services, in part, because it is a common belief that such cards -- being a relatively new product -- have been subject to the most problems and abuses. However, based on reviews of government oversight actions, we concluded that there may be problems with other types of discount cards, e.g., dental cards. In addition, discounts for hospital and physician services are almost always coupled with discounts for prescription medication, dental, vision, and/or other medical services. Based on this information, we made a decision not to exclude information related to other types of discount cards from this report. We do, however, recommend that a more thorough analysis of other cards, e.g., stand alone dental cards, be conducted in future studies especially if policymakers intend to exempt such stand alone products from current regulatory framework and consumer protections.

Finally, in reviewing government actions (court and administrative actions by the Federal Trade Commission, state attorneys general ("AGs"), and state insurance departments), the distinction between fraudulent entities selling phony discount cards and companies engaged in unscrupulous and/or unlawful activities in violation of state or federal laws was unclear in some cases. For instance, in a recent case a Florida-licensed company settled a law suit with the Texas AG; the AG alleged that the company was fraudulently and intentionally misrepresenting its product as health insurance, exaggerating discounts, and engaging in other unlawful activities against Texas consumers.<sup>2</sup> Because there were no criminal convictions in this and other similar cases and because this company is licensed, we described such activities as "problems" not as fraud.

# PART I: BACKGROUND -- PURCHASERS, COMMON CONSUMER PROBLEMS, FRAUD & ABUSE

## A. Purchasers

It is unknown how many people are enrolled nationally in discount medical plans. According to one industry source, there are 25 million people enrolled in discount medical cards nationwide and 4.3% of those have discounts for hospital and/or physician care.<sup>3</sup> In Florida, regulators report that over 1.5 million people are covered by licensed companies.

Good demographical information about purchasers of discount medical cards is not available. Generally, consumers who cannot afford health insurance, people with medical conditions for whom there are no private health insurance options, older populations, and immigrants buy discount medical cards. Monthly fees that are generally (although not always) lower than insurance premiums and advertising of up to 90% off fees for medical services make the product attractive to people who cannot afford health insurance.<sup>4</sup> One large company in the discount card business reports that most of its enrolled people are uninsured, underinsured or people with high deductible health plans.<sup>5</sup> Some large employers also offer these cards to their employees. One recent study found that discount programs are common among low and moderate wage workers without health insurance. Researchers report that nearly one in every five “nonstandard” workers, which include part-time, temporary and contract employees, had discount medical cards instead of health insurance.<sup>6</sup> Some small businesses have dropped health insurance for discount medical cards.

Additionally, discount medical programs target people who find it difficult to obtain health insurance due to past or existing illnesses. The private health insurance market does not serve everyone. In most states, in the individual market insurance companies have the right to turn people down, charge higher premiums, or not cover existing medical conditions. In contrast, discount medical programs are available to any consumer who wants to enroll, fees for existing medical conditions are eligible for discounts, and rates for the discount card are the same for sick and healthy cardholders alike. Thus, these programs appeal to people who were previously denied insurance coverage or who are only eligible for extremely expensive policies. To that end, discount medical card advertising material focuses on uninsurable people, stating “everyone qualifies!” or “...the only program geared toward uninsured consumers at risk or in need of ongoing medical treatment.”<sup>7</sup>

Marketers also target immigrant populations. Some marketers advertise in different languages and on Spanish-language television to draw immigrants into discount medical card programs.<sup>8</sup> Many complaints submitted to Florida authorities, for example, are from Spanish-speaking consumers. Some AG and insurance investigators have found discount programs specifically aimed at immigrant populations in California, Kansas and New York.<sup>9</sup> In 2005, California regulators noted that the majority of complaints were from lower-income Spanish-speakers without access to health insurance.<sup>10</sup> Finally, some programs are targeted at senior citizens.<sup>11</sup>

## B. Common problems reported by consumers and found by regulators and investigators

The most common problems identified by state AG offices as well as insurance regulators and investigators interviewed include: consumers believe or are told they are buying health insurance; small or no discounts; few or no participating providers; problems canceling enrollment; and outright fraud. State civil and administrative actions including cease and desist orders and cases filed by the government, describe many of these problems.

The Attorney General's office in Maryland reports:

The complaints from consumers reflect misleading sales promotion and exaggerated claims of savings. In addition, consumers have experienced great difficulty finding participating doctors or other health providers, and even if they do, the discounts are minimal. Some of these plans offer consumers the right to cancel their membership at any time; however, according to the complaints we have received, many consumers have found difficulty in canceling their membership once they realized the very limited benefits the plan offered to them.<sup>12</sup>

In California, regulators found that one multi-state entity engaged in the following conduct:

advertising and solicitation practices offer discounts from doctors, dentists, hospitals, and pharmacies that are unavailable...no doctors are available nearby...; providers will not accept the discount card; providers have not agreed to offer discounted prices, or providers give uninsured patients a discount off the amount insureds pay, so even with the card, a member would pay the same or less than if paying cash without the card. Nor are discounts available from pharmacies such as Costco, despite the fact that Respondent's Membership Guide lists Costco as a participating pharmacy.<sup>13</sup>

Prior to Florida's 2004 law, these problems also characterized Florida's market. Complaints registered with Florida's regulators in 2005 and 2006 indicate that, although most relate to unlicensed programs, similar problems with regulated programs continue.

Industry observations of problems echo those of the regulators. For instance, the Florida Association of Health Plans (an industry association representing health insurers in Florida) reports, "[t]he types of DMPO complaints our plans were made aware of included: Confusion over whether or not individuals had purchased insurance; Complaints about providers refusing to honor discounts; Lower discounts on services than were promised by the plan; High pressure sales techniques."<sup>14</sup> The following provides additional detail on common problems.

## 1. Consumers believe that they are buying health insurance

One of the most common misconceptions regarding discount programs that offer discounts for hospital and/or physician services is that the product is health insurance. According to a GAO study asking for states' experience between 2000 and 2002, 14 states reported that discount card programs were misrepresented as health insurance (more current nationwide research has not been done).<sup>15</sup>

***Consumer complaints from people who purchase the cards under the assumption that they are buying insurance are frequent, and many who purchase the cards incorrectly report that they have insurance.***<sup>16</sup>

### **Florida 2006 case: small business owners (with Ph.D.s).**

This family enrolled in a discount card believing it was health insurance. They received a fax advertising health insurance. Upon follow up, they were told to complete "an application for health insurance" with a health insurance company. They faxed the application and a copy of a check. An entity withdrew \$298 from their checking account. These consumers did not receive membership information and identification cards. When they tried contacting the entity, its voicemail was "full" and their call was disconnected. These consumers tried to contact the health insurance company, which had no record of the consumer as being insured. These consumers recently paid \$10,000 out-of-pocket for an emergency surgery. They also recently received their membership packet with identification cards for a discount program not health insurance. They had believed they were signing up for health insurance based on a health insurance application the entity sent them to complete and the high monthly fee.

*Florida's regulators are investigating this case.*

**Florida, August 25, 2006 public hearing before OIR, a consumer testified about her experience:**

Paula Wolf and her family moved to Florida for her husband's job. For dependent coverage through her husband's job, health insurance would cost \$499 per month just for Paula. She could not afford that.

In September of 2005, she found an affordable option through the web, which advertised affordable health insurance and an "open enrollment" period. For \$229.95 per month, she enrolled in "Smart Choice Health Care Diamond #2 Plan." Initially she was charged \$354.95, including the initial enrollment fee of \$125.

Paula who has medical needs, had to see a doctor and fill a prescription. Thus she needed her medical card and detailed information about the benefits. Not receiving either, while continued to be charged \$229.95 monthly, between October and December 2005 she called the company 17 times.

Paula said, "[I] [b]egged for assistance in getting this resolved – I was in tears while on the phone."

She tried to cancel this coverage in December, but was subsequently charged in January and in March. She did not receive enrollment information or the card but was charged a total of \$1274.75.

Paula testified, "I felt very violated. They prey on people because of the fears that you have of not being covered."

Here, a consumer believed that she was buying health insurance for a number of reasons.<sup>17</sup> The monthly fee was high, similar to a fee for some health insurance policies and the term "open enrollment" is typically used when signing-up for health coverage. Paula Wolf also testified that, when enrolling, she was told that she was buying health insurance.<sup>18</sup>

These cases are not unique to Florida and are illustrative of the types of problems that regulators report across states. For example, according to news reports, a consumer in California (a substance abuse counselor who understands insurance and medicine) signed up with HealthCare Advantage (enrolled through Peoples Health Plan) – a discount card – after she was told that the company was selling insurance. In the complaint with the state, the consumer described being told that she was enrolling in "health care insurance at a very low cost." She paid \$279 the first month (for herself and her husband). When she went to a doctor listed on the HealthCare Advantage web site, she thought she was insured only to learn later, when she received a \$500 bill from the doctor for the visit, that she was not insured.<sup>19</sup>

While some find out that a discount card is not insurance when their doctor or hospital informs them that they are responsible for their entire medical bill – as in the above case -- others discover it when they try to enroll in new health insurance. For example, according to press reports, one consumer (a diabetic since the age of four) after losing her job looked for insurance immediately. She knew that without continuous coverage, her diabetes would be excluded from new coverage as a preexisting condition. She enrolled in a program that looked like insurance. When she later enrolled in her new employer's health plan, she was informed that her diabetes would not be covered for a year because she had previously been uninsured. The product she had purchased between jobs had been a discount medical program, not insurance.<sup>20</sup> It is estimated that treatment and diabetes maintenance can cost on average \$346/month (\$804/month with complications).<sup>21</sup> Enrolling in a discount card (although not intentionally) in this case means that her new health plan does not pay for diabetes care, and that she is out of pocket as much as \$800 per month for one year (maximum allowable exclusion for preexisting conditions – 18 months for late enrollees).

***In Florida, consumers can be denied coverage, charged higher rates, and/or have their existing medical conditions excluded from coverage in the individual market.***<sup>22</sup>

Purchasing a discount card – believing it is health insurance and as a result dropping real health insurance -- can lead a consumer to become “uninsurable” for life, pay higher premiums, and/or not have their

preexisting medical conditions covered. This means a consumer will face significant financial and medical consequences as a result.

**Background on insurance access:**

Once a consumer needs medical services or care, in most states the consumer would be underwritten, which means he or she is not likely to be offered health insurance in the individual market because of existing or past medical conditions. Only five states require insurers to sell coverage on a guaranteed-issue basis (regardless of one’s past or existing medical needs). Other states have limited guaranteed access requirements, e.g., only for HIPAA-eligible individuals or others with prior continuous coverage. A discount card holder would not qualify for this limited guaranteed access. A handful of states require open enrollment periods during which insurers may not deny coverage due to a medical condition. Even if offered a policy, however, a person would be charged higher rates. Only five states prohibit insurers from charging people with medical conditions higher rates. Also new individual or job-based coverage is likely to exclude benefits for existing medical conditions (called “preexisting condition exclusions”) for a period of time or permanently in the case of individual coverage. If enrolling in job-based coverage, the health plan is allowed not to cover an existing medical condition for up to a year (18 months for late enrollees).

Providers are also confused by the blurred line between insurance and discount medical cards. Because discount card companies typically contract with provider network leasing companies (also called preferred provider organizations) instead of directly with providers, physicians may not be aware of how the program works. As a result, providers recognize the network logo on the card, assume that it is an insurance product (or third party payer as in a case with self-funded employers), and provide medical services assuming that an insurance company or another third party payer will pay the bills.<sup>23</sup> Confusion among providers is evident in the complaints regulators receive from providers who file insurance claims with discount medical card companies and are surprised that the claims are not paid. Hospital administrators also report that, in some cases, care is provided under the erroneous belief that a patient is privately insured.

**a. Practices that lead to this confusion**

Some discount card companies market their products as insurance, either explicitly or implicitly designed to induce consumers to believe they are buying insurance instead of a discount card. In a news report, the president of a large discount card company observed, “A lot of vendors are misrepresenting the product.”<sup>24</sup> She also stated “It’s so easy to sell a service over the Internet or put together a slick marketing brochure....It breeds shysters, if you will, and they purport it to be something it’s not – insurance.”<sup>25</sup>

We found evidence of both false statements and implicit misrepresentation. In one case in our 2005 study testing cards available in the Washington DC metropolitan area, we were told that the product we were enrolling in was insurance.<sup>26</sup>

Some entities use common insurance terms that lead to confusion and blur the distinction between the two products.

Advertisements can be misleading and intended to make purchasers believe that the discount medical cards are insurance. Companies solicit customers through a variety of materials, including television, the internet, fax blasts and cold-calls from telemarketers.

In each mode of distribution, terminology traditionally associated with insurance, such as “benefits,” “employee group health care,” “health plan” and “PPO rates,” is often used to attract customers looking for inexpensive health care coverage.<sup>27</sup> In a North Carolina investigation, the AG’s office found that telemarketers “tell consumers they can receive insurance-like benefits at a lower cost” and that despite the distinction, words like “out of pocket,” “co-payment,” and full “coverage” imply a traditional health insurance policy.<sup>28</sup> In a case in New York, a company advertised under a link titled “Health Insurance” on the state’s Chamber of Commerce web site.<sup>29</sup> Another company required consumers to complete a health insurance form in order to enroll in the program. Some marketers describe the product in terms of a percentage of a bill covered by the company (implying it is insurance), rather than the percentage by which a bill will be discounted (as in a case of discount cards).<sup>30</sup> Also, the names of discount medical card companies and the products they offer often sound like those of insurance companies.

Many of these advertisements then fail to include a disclaimer that explains that the discount plan is not insurance. In an Illinois case, the AG found that advertisements did not indicate that the cards were not insurance; instead they used insurance terminology like “all medical conditions accepted” and “ppo hospital network.”<sup>31</sup> Several states have issued cease and desist orders to companies that failed to explicitly state that their product was not insurance. (See Attachment A for a summary of state actions.)

Even when disclaimers are provided by companies, they often do not offset the otherwise strong indication in the marketing materials that the product is health insurance. One company, which was investigated by the state of Texas, informed consumers that the product was not insurance only after they signed up and received membership materials.<sup>32</sup> Other companies include disclaimers, but they are not easily seen or noticed by consumers. On websites, consumers may have to follow several links to find disclaimers that explain that the product is not insurance.<sup>33</sup> In commercials, disclaimers are often subtle and unclear. For example, an investigation by the FTC found that one company’s commercial advertised “if you don’t have health insurance, pay attention to this important message...for less than \$2.00 a day, your whole family can have access to doctors, dentists, hospitals, prescription medicine, 24-hour nurse hotline and more.” Also the commercial used insurance terms such as “deductibles” and “\$25,000 accidental death and up to \$5,000 of medical attention per accident.” According to the FTC, the disclaimer referred to the company with an abbreviation not utilized at any other time in the commercial, appeared at the bottom of the screen in small, gray font on a white background for eight seconds and was preceded by a sentence referencing insurance policies. The FTC argued that the disclaimer was easy to miss or disregard, and therefore did not counteract the strong implication of health insurance elsewhere in the ad.<sup>34</sup>

## **b. Bundling can contribute to misunderstanding of the product**

Bundling can give consumers the impression that the discount medical programs are health insurance. Bundling is a practice in which discount medical programs are sold in a package with other products, such as accident insurance that pays for medical bills resulting from an accident, or hospital indemnity insurance policies that pay a daily amount for hospital stays. For instance, one program sold via the internet includes a discount medical card, a \$5,000 accidental medical insurance benefit, and a choice of dental insurance, short-term disability insurance or life insurance.<sup>35</sup> Bundling insurance and non-insurance products -- where one of the benefits pays a person’s medical bills, e.g., a hospital bill in case of an accident -- leads to confusion. Also,

bundled products can be as costly as medical insurance, making the product appear more like health insurance.<sup>36</sup>

**Bundled products:** Packaging discount cards with insurance products that pay medical bills, coupled with high monthly fees, can lead consumers to believe they are purchasing insurance.

### **c. Misunderstanding of the product**

Some purchasers realize that a discount medical card is not health insurance, yet misunderstand the nature of the product and believe that it is better than health insurance. A consumer in South Carolina was paying \$113 monthly for a discount medical card because she believed it to provide greater benefits than health insurance.<sup>37</sup> Some marketers claim that the program offers the same or superior benefits when compared with the consumers' current insurance plan. Consequently, consumers may drop their health insurance for the discount program only to learn later -- after receiving their enrollment materials -- that the program is not better than health insurance.<sup>38</sup>

## **2. Discounts not as big as promised or illusory**

Another common problem is that discounts received on medical care and services are not as big as promised.<sup>39</sup> This problem relates not only to discounts promised for hospitals and physician services, but also for other medical services, including vision and dental care.

In a case investigated by the AG in Texas, one entity promised discounts of as much as 80%, but when consumers used the card, they "discovered that the fees for services were the same" after the repricing or "the discounts were negligible, and did not approach an amount that would justify the monthly fee" for the program.<sup>40</sup> The AG also found that "In some cases, 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," concluding that the "health care program is of no benefit to the consumer."<sup>41</sup> The AG also found that claims of discounts of 80% on health care services were not substantiated by the company.<sup>42</sup>

Investigations by AGs and insurance regulators in other states found similar problems of exaggerated or non-existent discounts. In the cases of several companies investigated by the New York AG, discounts advertised were much greater than those actually available. One program's advertisements and membership materials claimed savings of up to 80% on all health care costs. However, investigators found only about one fifth of the dental and medical claims were discounted at the advertised rate.<sup>43</sup> Another program claimed to provide savings of up to 50% on eye care fees, but only about one sixth of eye care fees were discounted at that rate and for one third no discount was available.<sup>44</sup>

In the 2005 study, we tested five cards promising discounts ranging from 15% to 80%. A range of 4% to 36% discounts was found, with many participating providers not offering any discounts at all to cardholders.<sup>45</sup>

*In recent testimony before the OIR, the American Diabetes Association (ADA) discussed the problem of exaggerated discounts. The following describes Arthur's problem. Arthur is a diabetic who called the ADA for assistance.<sup>46</sup>*

Arthur became uninsured after leaving his job to care for his ailing parents. He was unable to buy individual health insurance because of his diabetes – having been turned down by several companies. He bought a discount card from a friend, understanding that he could not be turned down and that it was not insurance. The program cost \$30 per month (but did not include discounts on prescription drugs, which he needed for his diabetes), and was promised a 20% discount on the cost of his office visits and any hospitalization or emergency room visit he might have. Arthur ended up in the ER when he had a problem with his foot and needed immediate treatment. He was disappointed when he received a discount of only \$85 on an \$849 bill. Over the course of three months, Arthur spent a total of approximately \$115 on both a non-refundable initiation charge (\$25) and monthly fees (3 months at \$30/month) to be enrolled in the program. Arthur's only discount was \$85 – less than the amount he paid the plan to be enrolled – making the discount medical card worthless to him. After adding up the costs of the monthly fees, initiation charge, and ER bill, Arthur spent \$30 more than he would have needed to spend had he just paid his ER bill out-of-pocket. Living on a fixed income, Arthur could not afford to waste the \$30.

In addition, even where there are discounts, due to additional fees, the savings are smaller than the consumer is led to believe. In one case investigated by the New York AG's office, although some claims were discounted by 80%, an administration fee equal to 25% of the cost of the service was charged for every discount received. Considering the fee, the discount received was never 80%.<sup>47</sup> In addition to a per transaction fee, some cards charge administrative and dispensing and banking fees.<sup>48</sup> Such fees also make the net discount smaller.

Additional requirements by discount card companies may also make certain savings through discounts illusory. For instance, to receive a discounted price, discount card companies typically require cardholders to pay the provider for care at the time of service.<sup>49</sup> In some cases, entities do not disclose this condition for receiving a discount until after a consumer has enrolled. In addition, some require cardholders to have enough credit available at the time services are received to cover the providers' standard fee in order to receive a discounted price. So a patient with enough funds to pay the discounted fee but not a standard fee would not receive the discount.<sup>50</sup>

For hospital discounts, it is typical to require that the entire hospital bill be paid within thirty days of discharge, and that a \$1,000 per day advance payment for each projected day in the hospital be made. Despite the importance of such information, some card issuers withhold these conditions from consumers until they have enrolled.<sup>51</sup>

***These conditions make a discount for hospitals an illusory benefit for enrollees not able to afford to prepay thousands of dollars for a hospital stay. Even when an enrollee can afford to prepay a few thousand dollars, it is unlikely that most patients can afford a \$100,000 hospital bill, even if discounted at 30% to \$70,000 to be paid within 30 days (or ever).***

A case in point is a resident of West Palm Beach who was paying \$40 per month for a discount program (having dropped health insurance that became unaffordable at \$800 per month). The discount card "barely made a dent" in an \$80,000 medical bill for cardiac catheterization her husband needed, according to news reports. This consumer was quoted saying "They are not what they're cracked up to be....You're better off to put your money in a tin can in the back yard and hope to God you don't get sick."<sup>52</sup>

### 3. Enrolled people cannot find a participating provider

Consumers report difficulty in finding participating providers, even when they contact providers on the lists supplied by discount medical card companies.<sup>53</sup> In some cases, a company's customer service representatives provide inaccurate or out-of-date information.

For instance, a consumer in Texas who needed surgery for prostate cancer contacted his discount card company to find a provider. He scheduled the surgery at the hospital that a discount card company representative directed him to. However, on the day of his scheduled surgery for cancer, the hospital informed him that it did not accept the card. Not wanting to further postpone his surgery, he hoped to clear up the misunderstanding with the discount medical card company after the surgery. However, when he later contacted the company, he was told that the hospital had opted out of accepting the program a year before he received his surgery, so he would not receive any discount. He was stuck with a bill for \$16,753.21.<sup>54</sup>

Government investigators have found this scenario to be a problem in many states. During its investigation of one medical card program, the New York AG's office contacted approximately 25 medical providers listed as participating in the discount medical program and found that none recognized the program.<sup>55</sup> In July of 2004, the Kansas AG filed a lawsuit against a Florida company alleging that the entity had misled about 280 Kansas residents by claiming to provide health care discounts but none of the listed providers accepted the discount cards.<sup>56</sup> During the same year, Montana's Insurance Department issued a cease and desist order against a company that claimed to have over 270 medical providers participating in the state, but a later investigation found none that accepted the card.<sup>57</sup>

In our 2005 study of discount medical cards, researchers called 44 providers that were either listed as participating providers or whose contact information discount card companies furnished in response to requests by researchers for names of participating local providers. Researchers found that some of these providers were no longer in business or the telephone numbers listed for them had been disconnected. Only 31 of the 44 providers were reachable and of those, 16 accepted the discount card. When trying to locate providers, researchers followed explicit instructions from each discount card company both as to finding participating providers and what to say when calling for an appointment. Even so, our researchers found it difficult to locate a participating provider who would honor the card in question.<sup>58</sup>

The turnover of physicians and hospitals in a network may contribute to the difficulties in finding a participating provider. Some discount card companies do not provide updated lists to cardholders, leading to genuine hardships for some cardholders.

Another reason for confusion about available providers is that, in most states, discount card companies are not required to have contractual agreements directly with the providers. Instead, they contract directly only with PPOs that lease their provider networks and not directly with providers. PPOs typically lease their networks to third party payers like insurance companies or self-insured employers. In other words, it appears that PPOs are not always adequately informing their own participating providers with respect to the following:

- (1) that the PPO has contracted with a discount card company,
- (2) that patients have a right to receive the PPO discounted rate, and
- (3) that patients, not third party payers, will be financially responsible for the entire medical bill.

As a consequence, providers in a network may not understand that they have been contractually bound by their own PPO to offer discounts to discount card holders, and that they are not dealing with patients who have bona fide health insurance.

Another reason that consumers cannot find a participating provider is because, in some cases, advertisements exaggerated the size of the provider network, leading consumers to believe incorrectly that many physicians and hospitals in their area participate in the discount program. In Florida, consumers report that discount card companies promised that many participating providers were located near their homes. Upon investigation, however, the closest providers were located as many as forty miles away from the cardholders' residences. Recently, Montana's insurance department issued a cease and desist order against a discount dental card company that had advertised 30,000 dentists and 7500 chiropractors nationwide. However, according to state investigators, "few, if any, dentists and chiropractors in Montana" have contracted with this entity.<sup>59</sup> In 2002, the New York AG issued an Assurance of Discontinuance to a company that advertised the participation of over 250,000 medical providers and 2,500 hospitals nationwide. In that case, investigators found that the claim of nationwide coverage was false -- no hospitals outside of New York, New Jersey and Florida accepted the card.<sup>60</sup>

#### **4. Cancellation and refund problems**

Cancellation of discount plans and obtaining refunds have been a major problem because companies are hard to reach, use high-pressure sales tactics, or provide misleading cancellation policies. It is difficult to reach some companies because either their voicemail box is full or calls are not returned after messages are left and a recording promises a callback within twenty-four hours. When consumers are able to contact the company, cancellation can be difficult. Some cards may only be cancelled in writing. Some consumers face high-pressure sales tactics in which they are offered free gifts if they remain in the program. Acceptance of these gifts is then considered an agreement to continue the membership.<sup>61</sup>

Marketing materials may also misrepresent or mislead consumers with respect to refund policies. Enrollers may seek to attract customers by claiming "risk-free" or "satisfaction guaranteed" memberships without disclosing the fact that refunds are available only within the first thirty days.<sup>62</sup> Refund periods may be shorter than marketers claim. For example, in one case investigated by the Florida AG's Office, consumers were led to believe that their thirty-day trial period began once membership materials were received; in fact, the period actually began on the day of enrollment. In this case, some consumers received their enrollment material only a few days before the end of the thirty-day period, while others received it after that period had lapsed.<sup>63</sup>

In a case investigated by the Texas AG, consumers were told that full refunds could be obtained if cancellation of membership was received within the first 30 days. But when customers attempted to cancel, the representative insisted that the refunds were only available within the first seventy-two hours of enrollment.<sup>64</sup> Similarly in California, investigators found that one entity's:

Marketing of a 30-day Satisfaction Guarantee also involves representations that are untrue and deceptive in that they fail to disclose that such refunds are available only to clients who use the program and are dissatisfied with the services they obtain; others who cancel in writing and return all materials to the company within the 30 days may receive only a 50% refund of their enrollment fee.<sup>65</sup>

In another case, California regulators noted that one entity's "Satisfaction Guaranteed" and a 30-day money back guarantee was "untrue and deceptive in that they fail to clearly and conspicuously disclose that the \$49 enrollment fee is not refundable."<sup>66</sup>

In a complaint filed with the AG's Office in Maryland, a consumer noted:

When I reviewed the materials in the package, only then did I discover that this was not an insurance policy...[I called to cancel]. He then informed me that [my mother] had to actually 'use' the services first....Aside from the deception of this position, it required my mother to have services she did not need at the time, and pay money she cannot afford for a medical visit she did not need. This is outrageous! (emphasis in the original).<sup>67</sup>

This case in Maryland illustrates that some discount card issuers require a consumer to use the discount card prior to cancellation. In other words, the cancellation right is restricted to allow only cancellation after a patient uses the discount card (and presuming the patient is not satisfied with the benefits).

The Federal Trade Commission found that a Florida-based company selling discount cards nationwide failed to provide an unconditional money-back guarantee despite the fact that sales agents promised it to consumers and advertisements claimed “no risk” and “sign up today without any risk.”<sup>68</sup>

In our 2005 study, researchers also documented problems canceling cards. In one case, the discount card offered one free month of membership to dissuade the researchers from canceling. The same company also had a complex cancellation process that did not comport with the cancellation process described in the enrollment materials. To receive a complete refund, the cardholder was required to send two letters to two different locations, and even then, only \$140 of the promised \$179.95 was refunded.<sup>69</sup>

Another problem is unauthorized charges appearing even after customers had successfully canceled their memberships.

In a recent case involving an entity based in Florida (that has “shut its doors” according to state investigators), a consumer enrolled in a medical discount card that had a 30-day cancellation clause. After cancellation, the discount card company drafted \$1,299.75 from this consumer’s checking account without authorization.<sup>70</sup>

**Florida consumer:** A consumer requested cancellation and returned the binders and membership cards as requested. But, her checking account continued to be charged. The consumer was charged the following monies from her checking account:

- October 7: \$334.95 (This is a \$125 enrollment fee plus the monthly fee of \$209.95);
- November 9: \$334.95 (charged a 2<sup>nd</sup> enrollment fee of \$125 in error);
- December 5: \$209.95;
- December 19: \$209.95 (She was drafted two times in one month instead of once and she had cancelled on November 28); and
- January 9: \$209.95.

The discount card company drafted \$1,299.75 from this consumer’s checking account without authorization.

***After an investigation, Florida’s regulators were able to obtain the full refund for this consumer.***

In another case in Florida, \$229.00 was withdrawn from a consumer’s bank account after enrollment was cancelled. The unforeseen, unauthorized withdrawal also cost her \$30 in overdraft charges.

There are similar reports in other states of unauthorized charges after cancellation of memberships. A Texas investigation found one company that continued charging consumers after they had been assured by company representatives that membership had been cancelled. Even in cases when the consumers had submitted the cancellation requests by certified mail, return receipt requested, and had received signed green cards indicating the receipt of the request, charges continued to consumers’ accounts.<sup>71</sup>

## 5. Outright fraud and misrepresentation issues

Outright fraud and misrepresentation have been and continue to be problems in the medical discount card market. Some operators and marketers have engaged in illegal activities ranging from selling cards for non-existent provider networks, claiming products are discount cards but in fact are unauthorized health insurance, and making illegal bank withdrawals and credit card charges. Mismanaged arrangements, while not out-right frauds, have also caused problems for enrolled consumers. Many state AG offices and state insurance regulators have issued consumer alerts and tip sheets warning consumers about phony discount card programs. Nevada, for instance, added information about phony discount cards to their consumer education campaign on phony insurance.

### a. Phony discount card companies: difficult to find

Phony discount card companies recruit members, charge fees and then disappear. In some of those cases, consumers do not receive the promised membership materials, despite finding charges or debits for membership and enrollment fees on their bank statements. In other cases, consumers receive a card, but there are no providers and no discounts.<sup>72</sup>

**Background:** An influx in phony discount card companies was first documented in 2003 during a nationwide cycle of health insurance scams – phony insurance companies that collected premiums for non-existent coverage and left hundreds of thousands of people with millions of dollars in medical bills and without health insurance. At that time state investigators reported an increase in unauthorized insurers disguising themselves as discount card companies, claiming exemption from state law because, by definition, state insurance laws apply only to insurance and not to discounts. Promoters of unauthorized coverage used discount programs as a subterfuge; they called a plan that was intended to pay claims a “discount plan.” In addition, some promoters collected monthly fees but did not have contracts for discounts with providers. In both cases, consumers became victims.

***Lack of oversight and regulation may be one reason that this market has attracted some unscrupulous individuals especially after states cracked down on phony insurance entities and the risk of being caught entailed criminal not merely civil charges for operating and promoting phony insurance arrangements.***

Investigators have observed that, in some cases, former insurance executives and agents have engaged in unlawful conduct by selling phony discount cards. In a case in Florida, an insurance agent who had lost his license and was under a lifetime ban from the insurance industry after an arrest for grand theft in 2000, was caught selling phony discount plans (with no provider networks). He was arrested for fraud and theft according to Florida’s Division of Financial Services.<sup>73</sup> Media investigations have found that certain operators have been “involved in suspicious business practices before,” such as one owner, who operated a mail order drug importation business that allegedly mislead customers about where their medication was coming from.<sup>74</sup>

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Investigating phony discount card arrangements is difficult and resource intensive. The entities perpetrating this fraud are hard to find because typically there is no or little contact information for investigators to work with. For instance, even if there is contact information, when investigators attempt to use it they find that the telephone number has been disconnected or that the voicemail box is full. Faxed advertisements often do not provide contact information except for a fax number.

Investigators note that traditional investigatory techniques do not always work to catch perpetrators. Tools used to look up phone numbers do not work well for tracing fax numbers, for example. Discount plans advertised through websites also provide minimal contact information and are hard to find. Some may not be based in the United States. Web-based addresses are difficult to trace due to different types of networks and tools and/or services used by some to obscure or hide actual geographic location (like using a proxy site to make their internet activities anonymous).

## **b. Marketing and cramming**

In some cases, telemarketers have enrolled customers in programs and charged their credit cards and bank accounts without consent. In one case investigated by the Florida AG's office, telemarketers altered recordings of phone conversations to make some customers' refusals of memberships appear a successful sale, and then charged their accounts for the memberships.<sup>75</sup>

***According to regulators, in many cases the only way customers can stop the unauthorized charges is to close the account.***

"Cramming," a practice of enrolling consumers without consent, often without contacting the consumer has also been a problem. A Florida investigation found that one operator charged numerous customers for memberships – the customers had not heard of or been contacted by the company. In fact, two memberships were charged to a man who was deceased before the recorded date of sale.<sup>76</sup> In another case, an Alaskan consumer enrolled in one discount medical program, and later found debits on her bank statement for a second membership in a different card company. The consumer had no prior knowledge of a relationship between the two companies and had not consented to a membership relationship with the second.<sup>77</sup>

## **c. Misrepresentation in marketing**

Many fraud and misrepresentation problems relate to advertisement and marketing. For instance, some advertisements claim that reduced rates and open enrollment are available only for a limited time, when in fact the rate does not change and any one who wants to enroll can do so at any time. For example, an advertisement asked consumers to "Respond Immediately to Assure Enrollment At The Reduced Rate of \$85-\$120 month" or "Mention code...to receive [the] reduced rate."<sup>78</sup> Another instructed consumers to call an 800 number to sign up at a special rate "good through Friday only!" However, consumers who respond to such advertisements actually receive a standard, pre-determined rate, regardless of when they sign up for the program.<sup>79</sup> Several states have taken actions against discount card operators based on such advertising (See Attachment A).

Some telemarketers for discount medical card companies also use deceptive techniques to enroll and retain customers. A Florida investigation found one company whose telemarketers offered "free gifts," such as airline tickets, to consumers who agreed to enroll in a trial membership. In reality, the "gifts" were merely vouchers requiring certain conditions to be met before they could be redeemed, which included various fees and taxes requiring further payment from the consumer.<sup>80</sup>

Some entities make false claims in order to gain the consumers' trust. For instance, one company claimed that it was in existence for forty years, when it had actually been established only in March of 1996. Another claimed to be endorsed by the National Health Alliance, but that entity does not exist. Another claimed that it was licensed by the "State Insurance Board," when it was not.<sup>81</sup>

## PART II: REGULATION AND CONSUMER PROTECTION

### A. Background

State oversight and enforcement authority varies. However, the AGs generally have some authority to investigate and prosecute illegal activities in the discount card market and, some AGs have used this general enforcement authority to help consumers victimized by such practices. In addition to the AGs, state insurance regulators in all states have authority to shut down unauthorized insurance companies. Some have used this general authority to shut down discount card providers and marketers. However, specific authority over true discount programs is only available in some states and varies greatly where available.<sup>82</sup>

#### 1. Role of state attorneys general

Generally, state AGs have authority under state consumer protection laws to stop unfair or deceptive practices like misrepresentation of products in marketing. Unfair trade and deceptive practices laws are enforced when there is a pattern of abusive behavior. In cases involving discount medical programs, the AGs have taken action in response to patterns of illegal activities. But, in practical terms, this means that AG actions are undertaken in response to problems (not preventive) and are brought only if more than one consumer has been hurt.<sup>83</sup>

Some AGs have also used other state statutes to take action. For example, the Texas AG's office alleged violations of the Texas Telemarketing Disclosure and Privacy Act, which addresses the marketing procedures of companies doing business in the state.<sup>84</sup> Pennsylvania's AG alleged violations of the state's Telemarketing Registration Act and the Fictitious Names Act, which requires entities to register with Pennsylvania's Department of State when they use "any assumed or fictitious name, style or designation other than" the entity's proper name.<sup>85</sup> Illinois' AG cited violations of the state's Preferred Provider Administrator law, which requires registration.<sup>86</sup> North Carolina's AG used the Telephonic Sellers Registration and Bonding Act, Telephone Solicitations Act, and the Discount Buying Club Act to obtain a preliminary injunction against one discount card company.<sup>87</sup>

To-date, in response to concerns about abusive practices and an increase in the number of victims, the AGs have taken a number of steps. For example, the National Association of Attorneys General has formed a working group to focus specifically on the area of discount medical cards. In addition, AGs in many states have devoted significant resources to investigate discount card operators, products, and markets. These investigations have resulted in court and agency actions (including settlement agreements in which investigated entities agreed to correct and to change their business practices).<sup>88</sup> States like New York, Texas, Maryland, North Carolina, Illinois, Kansas, Idaho and Florida are among the states that have brought successful actions.<sup>89</sup>

These AG actions rely on resource intensive investigations, which can take months or even years to conclude. Although some AG offices have been aggressive at stopping illegal marketing practices, not all have taken action, and none can prevent many of the problems related to medical discount programs.

***Consumers who rely on discount card membership programs as a way to access medical care, have very little assurance that what they are buying will actually give them promised benefits, access to doctors, and actual discounts. Furthermore, some consumers may not be able to receive help from an AG's office when there is a problem.***

## 2. State insurance regulators

State insurance departments are the principal state agencies with regulatory authority in the area of discount card programs. However, while all state insurance departments have authority to shut down phony insurance companies, discount card programs are not insurance, which makes it difficult for states to exercise this authority over discount card companies. Furthermore, investigations into unlicensed insurance companies can be time and resource intensive.

Regulators report difficulty in regulating discount card companies and stopping deceptive and abusive enrollment and marketing practices without specific laws directed at discount medical card programs.

***Specific and broad authority over companies and products significantly and directly impacts regulators' ability to protect residents effectively.***

A Maryland insurance regulator – from a state with no specific law on discount plans -- explained that, even when the practices of a discount medical card entity are deceptive or abusive, e.g., a consumer is told that the product is insurance, the authority of Maryland insurance regulators to stop such practices is limited or may not exist. Investigators and regulators from other states also report that with fraud and abuse cases, e.g., no provider networks, it is difficult to take action against sellers of non-insurance programs. Additionally, because it is time and resource intensive to investigate and take action in unauthorized insurance cases, it is not possible for these regulators to protect consumers effectively.

In some states, insurance regulators have successfully used their general authority over insurance products to address illegal activities by card issuers. Prior to enactment of a law directed at discount medical card programs, investigators and regulators in Montana successfully shut down some entities, using their general authority to close down unauthorized insurance operations (See Attachment A). Montana regulators had to argue that misleading information about these programs caused consumers to believe they were buying insurance and because of that, the state's authority to shut down unauthorized insurance entities was triggered. The state's use of this authority was not challenged. Subsequently, Montana's policymakers passed a new law explicitly providing insurance regulators with authority over discount card companies and establishing new standards for products and marketing. Because earlier actions had not been challenged in court, it remains to be seen whether regulators in other states relying on similar general authority would be as successful in shutting down discount card entities that have engaged in abusive or fraudulent practices. Other states, like Alaska, have used their general authority over the sale of insurance and agent licensing requirements to shut down discount card operators engaged in abusive practices.<sup>90</sup>

## B. Discussion

Although intervention by state authorities after the problems have occurred is important, without authority to prevent problems, it is difficult for the regulators and AGs to protect consumers effectively and comprehensively. Even when states successfully shut down illegal operations, there is little assistance for their victims. For example, if a consumer drops insurance coverage for a discount card claiming to be insurance, no law exists that would require his or her former insurance company to reenroll the misled consumer or require another insurer to sell a policy to such a consumer. This problem is particularly devastating for people with existing medical conditions or who develop medical needs while enrolled in a discount medical card. They become uninsurable in most states. This, in turn, impacts such persons' future ability to finance necessary medical care through private health insurance. In sum, as a result of fraud and abuse, some victims will never be able to recover. Similarly, no law exists to assist patients left with large medical bills after discovering that the product they thought was insurance is actually a discount medical card, and therefore did not cover their expenses.

***Post-problem authority, although important, cannot provide meaningful help to victims.***

There is also no help for consumers who suffer financially as a result of an illegal bank withdrawal. The potential harm to people on limited or fixed incomes can include the inability to pay rent, buy medicine or food, etc.

Although settlements between AGs and discount card operators or between state insurance regulators and operators in many cases have helped stop certain bad practices, to-date none have addressed these foreseeable consequences of the fraud, misrepresentation, and abusive market practices perpetrated by some discount card operators and marketers.

To conclude, the prevention of problems is a fundamental task for public policymakers seeking to protect consumers. To achieve that end, there has been legislative activity across the country. Some insurance regulators and state AGs have asked for legislation specifically directed at discount medical cards. In some cases, state legislators have initiated such legislation independent of requests for action by regulators. Other states were successful in passing new laws specifically directed at discount card companies and their products. The current wave of *comprehensive* legislation began with Florida's legislation enacted in 2004 and was followed by other states in 2005.<sup>91</sup>

## PART III: FLORIDA'S REGULATORY APPROACH

### A. Regulatory framework

In 2004, the Florida State Legislature enacted legislation authorizing Florida's insurance regulators to have oversight authority over discount medical plan organizations (DMPOs) and to set standards for discount card products. At the time, this legislation was the strongest in the nation; it helped to address fraud and abuse in the market, providing necessary protections for consumers. Based on 2005 annual filings with the OIR by DMPOs, it is estimated that over 1.5 million people have enrolled, paying over \$31.5 million for the cards in the first year of operation since implementation of the new law.

***To-date, this law has enabled Florida's regulators to address problems and to better protect consumers against questionable industry practices.***

Florida's law has served as a model for new laws in other states, including Montana, Nevada, and Utah – states that have experienced similar fraud and abuse problems. The National Association of Insurance Commissioners (NAIC) – an organization whose members are the nation's insurance regulators developing model insurance laws for states -- also based its recently adopted model law (passed unanimously in September of 2006) on Florida's regulatory approach (using Florida as the optional, comprehensive standard for consumer protection).<sup>92</sup>

Florida's law requires DMPOs to be licensed to do business in the state.<sup>93</sup> To qualify for licensing, a company must file an application with the following supporting documentation: the articles of incorporation; the corporation's by-laws; a list of the names, addresses, official positions and biographical information (including fingerprints and a background report) for all persons holding a position of executive control in the corporation (including voting shareholders who hold 10% or more of the company's stock); a statement describing the company, its facilities and personnel, and for what medical services discounts are being offered; a copy of contracts between the company and medical services providers like hospitals, physicians, and provider networks; a copy of contracts between the corporation and providers of services (e.g., marketing); audited financial statements; a description of proposed methods of marketing; and a description of the complaints procedure. In addition to its initial licensing application, a DMPO must file an annual report with the state, including an audited financial statement and any changes in its executive officers. It must also include information on the number of people it enrolled in the state. In 2005, policymakers further strengthened the law by adding a requirement for individuals in management and in ownership positions to be "competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers."<sup>94</sup>

To qualify for licensing, a company must have the financial ability to provide promised services. A company must maintain a net worth of at least \$150,000. It must also either obtain a bond of at least \$35,000 or maintain \$35,000 (eligible) securities deposited in trust with the insurance department.

The 2004 law also established new protections for people who enroll in discount medical cards including:

- a right to cancel within 30 days of enrollment for a refund of membership fees, minus a nominal processing fee (\$30), and if prepaid for more than a month, a right for a refund of membership fees for unused months;
- a right to access a current list of providers on-line through a web page. The web page address must be listed in all advertisement and membership material and access to the list of providers must be available to consumers pre-enrollment;<sup>95</sup>
- a right to access discounts without waiting periods.<sup>96</sup>

New consumer protections also include: a requirement that fees are reasonable, which includes filing rates with insurance regulators and a justification of monthly fees that exceed \$30.00/month; requiring disclosure of the price for the medical discount card, if it exceeds \$30 when offered (“bundled”) with other discounts or services, such as travel or legal services discounts.

Florida’s law also established standards for marketing, prohibiting misleading sales tactics and the use of terms that potentially could mislead purchasers into believing they are buying health insurance. A DMPO and its marketers may not use language in advertising such as “copay,” “insurance,” “pre-existing condition,” and “guaranteed issue.” The 2005 amendments clarified that DMPOs may use the word “insurance” in advertising only to clarify that the discount cards are not insurance. The law requires a DMPO also to disclose, in advertisements and any other marketing materials, that it is not insurance, that the plan provides discounts for medical services at some medical providers, and that it does not make payments for the services (the consumer must pay the discounted rate to the medical provider).

A DMPO must also disclose its name and address to consumers even when the product is “private label.” This means that when a reseller (or marketer) of a card uses its own name and own label for the program, e.g., name of an association, the card must also include the name of the DMPO.<sup>97</sup> All disclosures must be made in writing.

If a DMPO chooses to use marketers, it must approve in writing all marketing materials used and must have agreements with the marketers that they will only use approved materials. A DMPO must maintain copies of these agreements. A DMPO is “bound by any acts of its marketers, within the scope of the marketers’ agency, that do not comply” with the standards for DMPOs.<sup>98</sup>

Florida’s law also requires certain information to be included in agreements between DMPOs and providers. All agreements between a DMPO and medical providers must state what services and products are provided at a discount to members, the amount of the discount or a statement of the actual cost of the services (reflecting the discount provided), and a statement that providers will not charge members more than the agreed upon discounted rate. In these contracts, provider networks must agree to make available on an on-going basis to the DMPO an up-to-date list of providers.

DMPOs must file all forms -- membership booklets, member cards, and member contracts -- with insurance regulators. The law allows regulators to disapprove if forms are “unreasonable, discriminatory, misleading, or unfair.”<sup>99</sup> The statute requires regulator action within 60 days. A filing is deemed approved, unless it is has been disapproved within that time period.<sup>100</sup> A DMPO is also required to file its rates and if a price exceeds \$30, it must be justified. Additionally, the law authorizes insurance regulators to conduct market conduct examinations “to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest.”<sup>101</sup>

***The law provides Florida’s regulators with enforcement tools for oversight and for implementation of these standards. Form and rate filings and market conduct examinations are essential tools.***

In addition, regulators may impose civil fines and seek criminal penalties, suspend a license, and issue cease and desist orders. A willful violation of DMPO-standards is a second degree misdemeanor and anyone who operates, or willfully aids another to operate, an entity in the state that is not licensed as a DMPO but should be, may be punishable for the felony of being an unlicensed insurer. Finally, a person who collects fees and purposefully fails to provide the promised benefits has committed theft and is punished in accordance with such laws.

## B. Information from the Florida Office of Insurance Regulation

OIR has received 60 applications from entities seeking licensing. Regulators have used the same investigatory and licensing techniques that are used for insurers to investigate and review applications. Thirty-eight, of the 60 entities, qualified and were licensed as DMPOs (one is no longer doing business). A few withdrew their applications. Licensed insurers that sell discount medical products in Florida are required to add the DMPO line of business to their existing Certificate of Authority. Three of the 60 applicants were insurance companies that added the DMPO line – Aetna, Connecticut General, and Heritage Life.

DMPOs submitted 502 filings for approval of which 326 were approved. Others were withdrawn, disapproved, incomplete, or are pending. Each filing contained several “forms.” OIR also received 393 rate filings. Of those, five filed for rates over \$30 per month, which were not approved due to a lack of justification for higher rates. One rate increase that was filed was approved. Of the cards approved, 177 do not charge administrative fees, while 145 charge a one-time administrative non-refundable fee under \$30.<sup>102</sup>

***Because this is a newly regulated product and most companies in the market are not familiar with regulatory processes for licensing and oversight, OIR took a number of steps to ensure successful implementation and to create opportunities for companies to operate successfully in Florida’s newly regulated market.***

In early 2006, the office held a symposium for the regulated community, which included a workshop for DMPOs to help companies understand the new law, to help them apply for licensing, and to help with form and rate filing requirements. Regulators issued rules to clarify some of the statutory standards (Rule 690-203, F.A.C. – Part II – Discount Medical Plan Organizations). Additionally, regulators developed a “Discount Medical Plan Organizations (DMPOs)” guide for the regulated community, which explains the new legal requirements and how to properly file forms for approval. The guide provides tips (information for DMPOs on what to avoid because it slows down the review process) and options for compliance, a checklist for filing, and the name and background of a regulator responsible for form reviews should a DMPO need assistance.<sup>103</sup> For form filings, the office assigned several reviewers and each reviewed form undergoes a supervisor’s review to help ensure consistency in outcomes. Additionally, the reviewer provides assistance to the DMPO and feedback when changes to the submission are necessary.

Regulators report that prior to the law, there were nearly 2000 consumer complaints in 2003 and 2004 relating to discount cards. Since implementation, complaints have dropped by 90%, and most remaining problems relate to unlicensed DMPOs, which are referred for further investigation.

Complaints relating to unlicensed entities are similar to those reported prior to the 2004 law:

- failure to refund upon proper cancellation and unauthorized charges (withdrawals from bank accounts);
- consumers believe they have bought health insurance (and high monthly fees, \$200 to \$300);
- fax-blasts (including solicitation of regulated companies); and
- a myriad of customer service problems (like disconnected phone numbers).

Complaints are initially reviewed by OIR customer service staff, with a preliminary investigation conducted by staff and supervisors. These preliminary investigations include trying to find the entity's location, which is time and resource intensive, especially when there is little information about the entity's name. Cases that require a full investigation are referred to the Market Investigations division. Prior to the law, regulators did not have jurisdiction over medical discount cards; therefore, many cases were not referred. In 2003 and 2004, 59 full investigations were conducted.<sup>104</sup> In 2005, investigators conducted 45 full investigations. In 2006 (through September), there have been 21 full investigations on unauthorized DMPOs, compared to 11 cases on licensed DMPOs. This information does not include opened and on-going criminal investigations. Also, some "unlicensed" entities are affiliated with (or are subsidiaries of) licensed DMPOs.

Through market conduct examinations, OIR reports the following:

***Problems with licensed DMPOs are identified through consumer complaints and regulators' market conduct examinations or in many cases through form and rate reviews, prior to the sale of a product.***

- All DMPOs have had some problems complying with the law.
- Problems vary and include not properly disclosing that the discount card is not insurance and not refunding periodic charges upon cancellation.
- More than half of the licensed DMPOs have used misleading statements in advertising or web pages -- statements prohibited by the law to stop marketers from misrepresenting to consumers that a discount card is insurance.
- More than half have failed to comply with requirements for contracts with providers. Such requirements in the law are aimed at ensuring that provider lists are current and that contracts properly reflect benefits, discounts, and fees, which provides members access to services at a discounted rate.<sup>105</sup>

## C. Discussion

Standards for companies and qualifications for their managements, as well as financial requirements, are important for several reasons. They help ensure that a company seeking to operate in the state has a sound business model and is managed by individuals without a history of corrupt or illegal business practices. This is especially important given observations from investigators that former operators of phony health insurance companies became involved with discount card companies, once federal and state authorities cracked down on health insurance scams.<sup>106</sup> Financial requirements help ensure that the company has the ability to pay its contract providers or networks for access to discounts.

***Background PPOs:*** Networks of providers charge a monthly fee per member enrolled; thus a poorly capitalized entity may not be able to pay the necessary fees and consumers with a card would lose access to discounts if providers or networks cancelled the contracts for non-payment of access fees by a DMPO.

## 1. Standards for products: form and rate filings

Standards for products are also important. Discount cards are based on a promise to a purchaser that he or she will have access to discounts and that there are providers that offer such discounts when service is sought. These cards are more like insurance than other consumer commodities (e.g., a car). Purchasers are therefore not in the position to assess whether the promise is real, until they have paid for the card and have used it, by which time they may have paid hundreds if not thousands of dollars for a card that may be worthless because it does not deliver on its promises. To ensure that companies' promises reflect real discounts, a combination of standards and hands-on regulatory oversight is necessary. It is the only way to prevent problems before irreparable harm is done, e.g., a consumer with health problems drops health insurance believing a discount card is insurance, and becoming uninsurable in the private market as a consequence of such action.

**Background form and rate filings:** Form and rate filing requirements are fundamental and essential tools for state insurance regulators to prevent problems. Form filings are requirements to file copies of policies, contracts, and coverage summaries with the insurance department. Form filings seek to prevent regulated companies from selling products that are illegal or violate insurance consumer protection standards applicable to the product in question. Rate filings also seek to prevent problems by helping regulators to monitor rates to ensure that they are set in accordance with state law. Identifying problems through rate and form filings before consumers are injured is essential because once a problem occurs, it is not always possible to correct it in a way to make the injured consumer whole.

***The requirements for DMPOs to file forms and rates for discount medical cards are especially important given past and current problems.***

***In Florida, these requirements have allowed regulators to identify problems before products that violate the law are sold to Florida's consumers, and thus to prevent problems the law was designed to address from occurring.***

Regulators have approved only 326 of 502 filings to-date. While some are pending, many others were disapproved or withdrawn because they did not meet the basic standards in the law. An examination of the approved filings reveals that prior to approval, regulators required corrective actions in many cases in order to ensure that the products complied with the law, e.g., adding disclosures that a discount card is not insurance. The following are examples of problems prevented by regulator reviews:

- Through a review of forms, OIR identified a DMPO product bundled with a policy for limited benefit insurance. The coverage would be provided by an insurer not authorized to do business in Florida. Without the required approval process, Florida's consumers may have purchased coverage from an unauthorized insurer. This policy form was withdrawn.
- One policy form, a bundled product that offered both health insurance and discount card benefits, indicated on one page of its marketing brochure: "Note: there is never a requirement to use a ... [DMPO] Provider nor is there any financial or other penalty for choosing a non-participating provider. Benemedplus pays the same benefits whether or not a [DMPO] Provider is selected." It went on to state "This is NOT a health insurance policy. The plan provides discounts at certain health care provider of medical services."<sup>107</sup> These disclosures – a promise to pay health insurance benefits irrespective of whether a DMPO provider is used and a disclosure that benefits for using DMPO providers are not "health insurance" -- coupled with other features of the bundled product are likely to lead to confusion of consumers. This form was withdrawn.

- Regulators' review of rates resulted in five rate filings with rates over \$30 per month not being approved because none could justify the higher rates.<sup>108</sup> Some filings were withdrawn.
- One withdrawn rate filing was made for the Americans for Better Economic Resources (AFBER) – an association. According to the information submitted to regulators, AFBER, a not for profit association was established in 1984 “to provide beneficial products and services for its member [sic] who can immediately enjoy discounts on their healthcare needs.” Its list of discounted benefits includes home care services, elder care, pharmacy (compared to AARP benefits), dental care, vision care, hearing aids, funeral benefits, and other benefits appealing to seniors. While the discounts are “free,” the annual membership dues and fees ranged from \$2500 for the least expensive “silver plan” to \$4500 for the “platinum plan.” In addition to the discounts, the association did not provide any other benefits to its members according to the literature.<sup>109</sup> Had a rate filing not been required, it is likely that this product would have been sold to Florida’s seniors (especially given the types of discounts provided – elder care, home care, hearing aids, and pharmacy with a specific reference to how the product is better than AARP’s benefits). It is unknown whether annual discounts would have been worth an annual fee of \$4500 or \$375 per month to seniors (typically living on a fixed and often limited income).

## 2. Rates: background

Reviewing rates and requiring justification of rates above \$30 is one of the most important consumer protections in Florida’s law in part because prices have decreased compared to unlicensed products and compared to prices prior to the law’s implementation. This review of rates by regulators is also important because the nature of the product makes it difficult for consumers to assess whether the price of a card is fair, reflecting a card’s true value to the consumer.

Generally, when pricing a commodity, a company would consider its costs, risk, and profit (arguably the higher the risk then the higher the profit should be). For DMPOs, costs include marketing, contracting with provider networks, and maintaining a web page (not a significant expense) in addition to other administrative and fixed costs. The profit margin should not be greater than that of other comparable industries because the discount card company assumes no or little risk by selling this product. In the DMPO marketplace, price does not always reflect these principles. For example, the New York AG found that in one case consumers were charged different rates -- \$54.95 per month and \$120 per month -- for the same program (same discounts and providers).<sup>110</sup>

Certain characteristics of this product make it difficult for consumers to be wise shoppers. In theory, consumers looking to buy a discount medical card would shop around and buy the product based on information about its value and price. However, comparing discount cards by the cost for a card and available discounts is difficult for a number of reasons:

- (1) DMPOs are not required to and do not provide information about prices and discounts that a particular participating provider offers for a given service. Not knowing the price of service and the amount of discount makes it difficult to shop for a card that provides the most value.
- (2) Even if information on the amount of discount were available, a discount assumes that there is a set “retail price” that someone pays. In the case of physician services, the retail price may be a fiction – meaning that no patient or insurer pays the retail price because typically a physician’s rates are negotiated with one or more provider networks and patients pay the prices negotiated by the networks (which differ depending on the network). In other cases, physicians may have a reduced fee for “cash” or uninsured patients. So even a significant discount off a fictional retail price may not help measure the value of a card to the consumer.

- (3) Many discount card issuers contract with the same dental, vision, chiropractors, and physician and hospital networks -- receiving access to the same discounts. However the prices for the discount cards may vary significantly, even though the discounts are the same.

To conclude, these and other reasons make discount medical cards different from other commodities. Consumers cannot shop around smartly for the best “value” or product that suits their needs.

Absent regulatory oversight, discount cards can cost hundreds of dollars per month but may provide little or no value, even if they are not outright “phonies.” There is no question that these products are used as an alternative or as supplements to health insurance. They, therefore, must be regulated and monitored carefully, as it is an important public policy goal to promote access to needed medical care and services by all state residents. Because consumers are not in a strong position to assess the true value of discount medical cards in general and with respect to their own medical circumstances in particular, regulatory oversight and review of cards and prices are the only way to protect consumers. Regulators are in a position to protect consumers by preventing price gauging and the selling of products with no value, if they have the specific authority to review products and prices.

### 3. Market conduct

Florida’s regulators made a decision to conduct an examination for compliance. The compliance examinations were scheduled to begin six months after the company was licensed or six months after effectuation of the DMPO law. The six month time period was to permit the DMPOs to restructure their policies and procedures in order for each DMPO to be compliant. Because DMPOs are a newly regulated industry, regulators’ reviews and feedback are helpful to the companies and necessary to ensure compliance with the new law. In September 2006, the OIR made public the final market conduct reports on three DMPOs – Aetna Life Insurance Company, Starmark Benefits, Inc, and Compbenefits Company – focusing on discounted dental plans (that also may have other discounts available to enrollees at no additional cost to the enrollee). Each of the three DMPOs had some (or most) of these problems:

**Background market conduct.** Through market conduct examinations (periodic or targeted audits designed to look at a specific practice or suspected problem), regulators can and do find problems and noncompliance with state law. Such examinations are typically conducted at a company’s offices on-site and involve review of operations, processes and procedures, interviews with company personnel, and review of relevant documents including telemarketing scripts to identify potential and actual problems. Market conduct examinations help to correct problems without the need for formal disciplinary or court actions. By stopping on-going problems, such authority helps to prevent future injury to consumers.

- use of unapproved forms (e.g., that failed to disclose renewal, termination, and cancellation conditions, limitations to benefits, and complaint procedures);
- failure to issue refunds upon proper cancellation;
- use of prohibited terms in advertising that are likely to mislead consumers about the nature of the product; use on a web page of prohibited terms like “copayments,” likely to mislead consumers;
- failure to provide up-to-date provider lists on a web page;
- failure to follow stated internal grievance procedures to resolve complaints;
- use of telemarketing scripts without required disclosures (e.g., not insurance); and
- failure to provide members with correct contact information (web page and telephone numbers) for the company.<sup>111</sup>

These DMPOs either corrected or are in the process of correcting such problems. Absent market conduct examinations, these unlawful practices may have continued and consumers may have been hurt.

## D. Response from the regulated community

The response from the regulated industry has been mixed. For instance, at a public hearing held by the OIR on August 25, 2006, members of the regulated community testified about the law and oversight efforts. Testimony from Blue Cross Blue Shield of Florida and a PowerPoint presentation submitted by Florida's Association of Health Plans focused on the positive impact of Florida's legislation but both warned that additional regulation should be weighed against the need for the industry to innovate. Each agreed, "The DMPO law and regulations adopted by the OIR have served an important purpose in regulating a market that was previously unregulated and subject to abuse. The prior DMPO marketplace needed regulation as certain market entrants misrepresented their offerings and took advantage of some Florida residents."<sup>112</sup>

The representative from Blue Cross Blue Shield of Florida also made the following points:

Anecdotally, I have observed a significant reduction in the number of misleading roadside and fax advertisements for DMPOs. No longer do we see as many signs advertising Discount medical plans with slogans like: *Affordable Health Care Plan; Pre-existing conditions? No problem! No Deductible or Co-pays; Thousands of providers in our PPO network; Discounts up to 60%*

While additional regulation of the DMPO marketplace may be necessary, more education and awareness among consumers of the purpose and value offered by discount medical plans versus traditional insurance should be a key element in any analysis of the current state of the market....Since Discount Medical Plans are not insurance consumers need to understand certain realities. Here are two key concerns: Discount Plans pay no actual benefits toward the cost of coverage. Thus, even with the discount, the consumer may still face a large bill, particularly with hospitalization or surgery; Discount Plans are not insurance – as such if a person becomes sick while covered under such a discount plan, this may, in fact, make it difficult for the consumer to obtain actual insurance when they really need it. (at least in the case of individual coverage).<sup>113</sup>

He concluded with, "Finally, additional regulation of this marketplace should not serve as a hindrance to innovation and specialized discount plans that have value to consumers."<sup>114</sup>

Florida Association of Health Plans (FAHP) noted in their PowerPoint presentation that the "Most important are regulations that protect consumers from being misled to believe that DMPOs offer the same protections as health insurance. Due to OIR's implementation of Part II, Chapter 636 Florida Statutes, we have significantly reduced the number of questions and complaints that our plans have received since the regulations took effect in 2005."<sup>115</sup>

A lobbyist for a trade association representing some licensed DMPOs (Consumer Health Alliance or CHA) testified that there are aspects of Florida's current regulation that must be changed and that he will continue to seek legislative fixes.<sup>116</sup> There was also testimony from other industry representatives. Copies of testimony and presentations are available through OIR web page at: [www.floir.com/DMPOHearing/index.htm](http://www.floir.com/DMPOHearing/index.htm).

OIR held the public hearing in part to determine what changes (if any) are necessary to improve Florida's laws covering discount medical cards to better protect consumers and to create a good business environment for bona fide entities seeking to operate and sell this product in Florida. The hearing occurred two months after the Governor had vetoed legislation that would have significantly restricted the regulatory authority of the OIR. The principal proponent of the 2006 legislation was CHA, whose members sought legislative fixes to statutory requirements they found difficult to comply with or requirements they believe do not serve public policy goals.

## E. 2006 Bill summary, discussion, and implications

As a way of background, in the 2006 legislative session, Florida's legislature passed House Bill 1361 that would have substantially changed standards applicable to DMPOs and restricted OIR oversight authority over DMPOs. Kevin McCarty, Commissioner of Insurance, OIR opposed the proposed changes. The bill was vetoed by Governor Bush. According to the Governor, "The Provisions in this bill remove some of the necessary consumer protections that were put into place in 2004 and 2005. Given the importance of these plans and the increased consumer protection that has been afforded by thoughtful and negotiated changes to the law in 2004 and 2005, I do not support changes made in the bill to reduce state oversight of discount medical plan organizations and increase the cap on monthly charges."<sup>117</sup>

The changes CHA sought and the legislature passed include the following (not a complete list):

1. *Eliminating the requirement to file an annual audited financial statement.*

An audited financial statement is an independent tool available to assess the financial condition of a company. Companies estimate that an audited statement costs approximately \$30,000. They argue that because discount card companies do not pay claims directly and are not risk bearing entities, this requirement is an unnecessary expense that serves no public need. We believe that because policymakers have sought to ensure that only financially stable companies provide discount cards to Florida's consumers, eliminating such requirements may adversely impact this important public policy goal.

2. *Restricting regulators' authority to examine or investigate DMPOs to cases where "the Commissioner has reason to believe that the discount medical plan organization is not complying with requirements of this chapter."*

The current authority does not place such evidentiary requirements on OIR and allows OIR-initiated investigations to ensure compliance with the law. The current structure provides for greater protections for consumers than the proposed change because it allows the OIR to examine companies before violations occur that injure consumers.

3. *Allowing DMPOs to impose restrictions, like waiting periods or notification requirements, before enrolled consumers would receive discounts for hospital services.*

Waiting periods are common in health insurance. Typically, employers have a waiting period before health benefits become effective for new workers. Workers do not pay premiums during a waiting period. Such periods are also found in individual health insurance policies, with the insured person not being eligible for certain benefits (e.g., organ transplant) until they have been covered for a period of time. But after initial enrollment and being covered under a policy for a specified period of time, there are no waiting periods for benefits. Because discount cards are not insurance, adverse

selection problems do not exist that could expose a DMPO to financial risks (consumers pay the hospital bill, not the DMPO).

A DMPO's potential need for such limits stems from the fact that hospitals participating in discount programs require a prepayment (typically \$1000/day for each anticipated day in the hospital) and full payment within 30 days. A waiting period would give the DMPO an opportunity to collect the required prepayment. If policymakers choose to change the current restriction on waiting periods -- a short period of time to arrange for the prepayment may be appropriate -- this must be accompanied by a suitable disclosure to the consumer (fully explaining this delay in access to discounts). If a consumer has a credit card, for instance, then a hold or a deposit using the credit card would not take more than a day and in such circumstances a waiting period should not apply.

As policymakers weigh the administrative need for DMPOs to ensure prepayment for the discount, a consumer's medical need not to delay surgery should also be considered. Also, if a waiting period for discounts is allowed, there should be a standard (10 days for instance) to arrange for the prepayment and available exceptions when a consumer has the means to prepay instantly (with a credit card) and for emergencies.

4. *Increasing the amount companies could charge for discount cards for physician and hospital services from \$30 per month (or \$360 per year) to \$60 per month (or \$720 per year) without seeking approval.*

This change would likely result in companies doubling their rates. Currently, if a DMPO seeks to charge a fee higher than \$30, it must justify it and receive approval from regulators. Regulators have not approved higher fees because DMPOs could not provide justification for those higher fees. It is unclear what public policy goal doubling the fee would serve and how this would protect consumers.

5. *Requiring the disclosure of fees associated with the medical discount plan included in a bundled product only if the medical discount plan is bundled with an insurance product.*

Currently, disclosure is required even when the medical discount card is bundled with non-insurance products such as travel discounts, discounts for legal services, or other non-regulated products. Changing this would mean less information for consumers about the cost of the discount medical card, which would make it harder for consumers to make informed choices about the cost to access medical discounts. In a for-profit competitive marketplace, more information and suitable information about products is necessary to enable consumers to make informed choices.

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Through interviews with some of the industry stakeholders in Florida, we identified additional issues that the regulated community believes to be problematic under Florida's regulatory framework. Some suggested that Florida's law (statute and regulations) and enforcement focus too much on legitimate, licensed companies and not enough on the illegal activities of unlicensed companies operating in the state. One industry representative stated that, although licensed companies report illegal operators to insurance regulators, such illegal entities and complaints are not investigated. (We were not able to find evidence of this, however.) In terms of the focus on licensed companies, some in the industry note that market conduct exams cost each company approximately \$10,000 and slow down their business operations (as staff are diverted to handle the market conduct examinations). Furthermore, according to consumer complaints, most problems relate to unlicensed entities. Therefore, some industry representatives argue it would be a better use of resources to focus on illegal entities, rather than devoting significant resources to monitor licensed companies that are attempting to comply with the law. (See Part V: Recommendations and Conclusion for ways to address this.) Given the on-going problems with licensed products, however, it is premature to divert resources away from monitoring licensed companies. Over the

long-term, it also would not serve the public's interest if licensed companies are not monitored for compliance with consumer protections enacted by state policymakers.

Industry representatives also expressed a concern that some standards in the law are vague, making compliance efforts more difficult. One example of this relates to the requirement that any discount card organization charging in excess of \$30 per month must obtain the approval of regulators. Some members of the industry suggested that this requirement and its implementation have been problematic because there is no clear standard that companies can follow to receive an approval for rates higher than \$30 per month. According to industry representatives, part of the impetus for seeking a legislative change (increasing the threshold to \$60 per month) is the uncertainty over what information is necessary to receive approval for higher rates. (See Part V: Recommendations and Conclusion for ways to address this through additional guidance). A related concern is that some companies believe that the process for form approval is arbitrary and that whether a product is approved depends not on the law but on how the reviewer interprets the law. We were not able to find evidence of this, however.

In addition, some noted that standards in the regulations implementing the statute may not work well for different types of products, e.g., group products are different from individual products. The industry representatives also noted that these issues are part of their on-going discussions with the regulators.

## PART IV: REGULATORY APPROACHES IN SELECTED STATES

New state laws directed at discount medical cards include requirements for licensing, registration, and a hybrid of the two. Key differences among state approaches relate to:

- standards (or none) for companies operating such programs or selling/marketing the cards;
- specific standards (or none) for products, rates, and marketing;
- purchasers' right to information relating to participating providers and discounts they offer; and
- scope of oversight authority, including problem prevention and post problem jurisdiction.

For this study, we identified several states that have been aggressive in seeking to combat fraud and abuse in the area of discount medical cards. In addition to interviews with insurance regulators and investigators, we interviewed state attorneys general offices. Based on that broader research, we chose to examine, closely, oversight activities and new laws passed in Montana, Nevada, Utah, and Alaska. Regulators in these states have been active in helping to protect their residents from abusive, and in some cases fraudulent, practices engaged in by some discount card companies and promoters. Each has sought and was successful in obtaining legislative changes and new authority over discount medical cards. We also include information about California, a state that has taken the position that discount medical programs are subject to its managed care licensing laws and product standards.

### A. Licensing vs. registration for discount card companies

Seeking to regulate the discount medical card industry, some states now require discount medical card companies to obtain a license or to register with the state in order to operate lawfully. The amount of authority each licensure or registration law provides varies. In the case of some states that label their new laws "registration" (Montana and Nevada), the new laws provide insurance regulators with broad authority to investigate prior to allowing an entity to register (akin to authority over insurance companies applying for licensing).

#### 1. Montana

The Montana Medical Care Discount Card and Pharmacy Discount Card Act became effective in October 2005.<sup>118</sup> It requires an annual registration with the insurance department. Licensed insurers are not required to obtain registration, however, their affiliates are. The law established standards for companies and products.

Based on this new authority, the insurance department requires the applicant to submit the following information with its request for registration and to meet certain qualifications:

- meet financial standards (a bond worth at least \$50,000);
- provide biographical affidavits for all officers and directors, as well as for manager or point of contact for Montana business;
- provide information for owner and/or controlling entity;
- provide all names under which cards will be marketed;
- information on operator and/or affiliate's prior actions relating to certificate of registration denial, revocation, suspension, or termination for cause; if under investigation for, or having been found in violation of a statute or regulation in another jurisdiction within the previous 5 years, the entity is not eligible for registration in Montana;

- provide information about expertise operating discount card business;
- description of how cards will be advertised or promoted (with sample advertisements, sample card, and sample purchase agreement);
- a list of health care providers or evidence of a contract with provider networks with information how enrolled people can access a list of all providers;
- a list of all authorized enrollers in Montana with address, phone numbers, and social security numbers (the entity must also certify that its enrollers have not been subject to any legal actions in other states).<sup>119</sup>

There are also product standards for discount medical cards, which include:

- prohibition on misleading or deceptive representations about the amount or availability of discounts;
- prohibition on use of terms related to insurance or that could lead a consumer to believe that the product is insurance;
- requirement that a list of participating providers and their specialties and locations be provided through the internet or a toll-free number before a consumer enrolls;
- disclosure in bold type on all materials that the program is not insurance; and
- a 30-day cancellation right from the date of delivery of card with a full refund minus a “nominal” administrative fee. Discount card companies may not charge a fee for canceling.

The legislature also amended Montana’s insurance fraud statutes to include fraud associated with discount cards. Montana does not require prior approval or review of forms and rates.

The registration process for discount card companies is similar to the licensing process for insurance companies – applications and the companies are fully reviewed and investigated prior to authorizing the registration. Out of approximately 20 applications submitted, 7 companies were allowed to register. Some entities withdrew their applications for registration because they were under investigation or subject to regulatory actions in other states. The department has on-going investigations of licensed and unlicensed companies, although it is not engaged in formal market conduct examinations.

## **2. Utah**

Utah’s policymakers enacted the Health Discount Program Consumer Protection Act, which became effective in September 2005.<sup>120</sup> The statute requires medical discount plans to be licensed by the Insurance Department. A company must submit the following for licensing: articles of incorporation and by-laws; biographical information about the company principals; a copy of the contract forms used to execute contracts between the plan and health care providers, customers, and marketers; a proposed marketing plan; and company’s customer dispute resolution process. Companies must also notify the Insurance Department before changing the company’s name, business address, or ownership. Health insurance companies are exempt from licensing but must comply with standards applicable to the product (and must file annually a list of services provided at no cost to enrollees).

Utah’s policymakers also established standards for discount medical card products and marketing. Among some of the new standards are: a prohibition on the use of common insurance terms; new disclosure requirements; prohibitions on restricting access to discounts, and a right to cancel within 10 days of enrollment for a full refund, including administrative fees.<sup>121</sup> Utah’s law requires all customers to sign a contract that discloses the terms of the plan, including monthly fees, procedures for securing discounts, and cancellation policy. Written materials, including advertising and marketing materials, must be filed with the Insurance Department prior to use.

Similar to Florida, regulators have not approved some submitted forms. According to regulators, one was denied approval, for example, because the entity refused to remove the phrase, “hospital discounts of up to 80%” are available,” from its advertising materials. Rate information is not required to be filed. If products are bundled with an insurance product, such products are allowed to be sold only by licensed producers (agents and brokers). The discount card company must become licensed as a producer or demonstrate that the product will only be marketed by licensed producers.

Similar to Florida and Montana, Utah’s policymakers clarified that unlicensed medical discount plans are considered unauthorized insurers and are subject to the same penalties as unauthorized health insurers. Almost identical to Florida’s law, any person who commits a fraudulent act in connection with a health discount plan is guilty of a third degree felony. Over 20 companies have been licensed in Utah so far.

### **3. Nevada**

Nevada also adopted an approach similar to the one used in Florida, Montana, and Utah – establishing standards for companies and for products. Nevada’s “registration” law, which functions like licensing, became effective in October of 2005.<sup>122</sup> Financial standards include a net worth requirement of \$100,000 and submission of audited financial statements. Biographical information on the individuals operating the company must also be submitted. Copies of provider and network contracts must also be filed with the regulators, as well as a copy of the marketing materials with a description of the marketing method. Nevada’s law also mandates submission of information about an entity’s status in other states, including information about revoked insurance licenses, as well as information pertaining to charges, arrests or convictions of misdemeanor or felony cases. Nevada requires affiliates of insurers to register. However, insurers offering discount medical cards for no fee are exempt; if offering for a fee, then insurers are not exempt. Resellers (meaning companies that use their own name on the card, also called private label, co-branding, etc), are considered to be subject to the same requirements and must also register. Resellers must also list all marketers of the product.

Standards for products also include marketing, new disclosures, and prohibitions on the use of certain terminology associated with insurance. Nevada’s law specifically authorizes regulators to examine records (market conduct examinations) to determine compliance with the law. Nevada has approved 21 of the 22 applications received so far (1 did not complete the application process). The department is in the preliminary stage of formal market conduct examinations, although it has been conducting case investigations on an on-going basis.

### **4. Alaska**

Different from Montana, Utah, and Nevada, Alaska’s policymakers did not establish licensing standards for companies offering discount medical cards. Entities offering only discount cards are not required to be licensed or registered with the state (the exception is if they include an insurance product in their marketing). New marketing standards, however, were added to the law in 2005.

The “Trade Practices and Fraud” provisions of the code were changed to include: new disclosure standards; a requirement for a contract with each provider; a requirement to make available an up-to-date list of participating providers and the discounts offered; and a right to cancel within 30 days of purchase (for a refund minus a nominal fee).<sup>123</sup>

Alaska’s statute suggests and insurance department staff have interpreted the law to require companies to contract directly with providers (not through a preferred provider network). This interpretation was recently challenged. According to regulators, an administrative law judge upheld

the staff's interpretation. However, this was not a final order. It was an interpretive (or suggested) ruling. If the Director of Insurance adopts the recommendation of the administrative law judge, the decision is likely to be appealed by entities offering discount cards that wish to contract with networks instead of directly with providers.

The statute also prohibits the misrepresentation or false advertising of health discount plans as health insurance policies. Misrepresentation includes "any statement or omission of a statement that when taken in the context of the whole presentation may tend to mislead or deceive."<sup>124</sup> If insurance terminology is used, the product is considered subject to the insurance code and treated as unauthorized insurance. If a product includes insurance, like accident insurance, it must be sold by a licensed agent. No filings with the insurance department are required unless a discount card is sold with an insurance product. The Department is conducting on-going case investigations.

## 5. California

California's regulators have taken the position that the requirements applicable to managed care companies under the Knox-Keene Health Care Service Plan Act of 1975 also apply to discount medical card companies.<sup>125</sup> A health service plan would include "any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees."<sup>126</sup> All standards applicable under Knox-Keene would apply to discount medical cards, including standards for companies and products, as well as the authority of the California Department of Managed Health Care (DMHC) – the principal regulator of managed care plans in California.

In September 2006, an administrative law judge agreed with DMHC's interpretation that the Knox-Keene Health Care Service Plan Act applies to discount medical cards that undertake to arrange for provision of health care services.<sup>127</sup> This decision may be appealed or the question of the application of Knox-Keene may be litigated in a different case.

Although DMHC has cited lack of licensing as a basis for many of its cease and desist orders against discount medical programs and has obtained consent orders from such companies promising to initiate licensing proceedings, to-date none of the companies that promised to seek licensing appears to be licensed.<sup>128</sup>

Also, a number of bills attempting to establish a new regulatory framework specifically for discount medical cards, including one that would outlaw discount medical cards in California, have been introduced.

## B. Discussion

It is uncertain whether California's general managed care laws would protect consumers enrolled in discount medical programs. It is also too early to tell whether the new regulatory framework established in Montana, Utah, Nevada, and Alaska will be effective in protecting consumers and addressing fraud and abuse problems. Nevada and Utah have not completed market conduct examinations on the licensed/registered companies and therefore information about compliance with each state's standards is not available. Conducting market conduct examinations in Nevada and Utah may yield important information about how well consumer protection standards are working for products sold by authorized companies. Montana's structured market conduct examination procedures do not apply to discount card companies. However, regulators can investigate and conduct other oversight activities. Those have resulted in fines and in cease and desist orders against unauthorized entities. Information about investigations of registered discount card companies is not publicly available prior to formal action.

Regulators believe that having a law (regardless of how stringent or consumer protective it may be) is enough to discourage some unscrupulous individuals from entering the market and gives regulators much needed authority to go after phony discount card entities. All regulators interviewed note that consumer complaints have decreased, once the laws became effective. This is early evidence that there is a deterrent effect in having specific standards applicable to discount medical cards.

***For policymakers looking for ways to protect consumers against fraud and abusive practices by some, one key question is whether government officials have authority to prevent problems and adequately address problems once they occur.***

Montana, Nevada, and Utah conduct full background checks and investigations on companies seeking authorization to do business (either through licensing or registration). This helps to identify potential problems on the operations side of a company, e.g., managed by a convicted felon. In Montana, entities are

not eligible for registration if they and/or their executives are under investigation in another jurisdiction or have had actions taken against them during 5 years preceding the application for registration. This is one way to avoid potential problems with entities that have been investigated or subject to action in other states. Minimum financial requirements like those imposed by Nevada and Montana seek to ensure that a company is financially sound and able to provide the promised discounts to card holders.

Form (including advertisements and marketing material) and rate review authority is essential to prevent problems and consumers being hurt. Montana and Nevada, require companies to submit sample forms as part of licensing, however neither reviews each form related to a program offered prior to its sale. Utah requires all forms to be filed with the insurance department prior to their use. Montana, Nevada, and Utah do not require rate information to be filed. Regulators report high prices for some discount medical cards, especially when discount cards are bundled with other products like accident insurance.

States also vary in their approach to oversight of marketers and/or resellers (a.k.a. "private label"). Whether there is direct authority over marketers is important because many of the reported problems relate to marketing. Also, because marketers are not licensed insurance agents, standards including training and penalties applicable to licensed agents do not apply to marketers of discount cards. Some states hold the regulated company accountable for violations of the law by its marketers; this encourages companies to be more careful in selecting and training its marketers. In Montana, the discount card company is responsible for the activities of its marketers and enrollers in connection with the marketing and selling of the cards, and must provide a list with their names to the state; the information on the list must also include any action taken against the enroller in other states. Nevada and Utah also require marketers' information in applications for registration and licensing. With respect to resellers (private label products), both states apply their standards to resellers. This means that resellers like Sams Club and Costco must also register and/or be licensed. These regulatory approaches allow regulators to identify and prevent problems caused by marketers and resellers.

With respect to new standards for this product, states vary in their approach on the following key issues:

- a right to a refund;
- access to a list of participating providers and information about specific discounts; and
- requirements for contracts with medical providers.

Applicable laws in Alaska, Montana, Nevada, and Utah include standards for refunds. However, these vary significantly. For instance, Montana requires entities to allow consumers 30 days to cancel the membership. The right to cancel in Montana starts from the date of delivery of the card

not from the date of purchase and so consumers in Montana have 30 days to test a product. Alaska and Montana allow companies to keep a “nominal administrative fee” and so trying the product has an actual cost to consumers (not a 100% refund). Utah allows a 10-day right to cancel. Nevada does not specify a cancellation right but requires a refund to be processed within 30 days of notice when there is proper cancellation.<sup>129</sup>

Cancellation rights are important because they give enrollees an opportunity to test a product, and to make sure that promised discounts are actually available. The amount of time and the triggering event for this right are important also. Because it could take weeks to receive enrollment information, the triggering event for cancellation impacts whether a purchaser has adequate time to test the product.

***A full refund (including administrative one-time fees) also helps to ensure that a consumer who was misled about the product, e.g., enrolling with a false belief that it is insurance, receives a full refund and that a discount card operator does not benefit financially from a potentially unlawful practice of its marketer.***

States take different approaches with respect to pre-enrollment disclosure of information relating to providers and discounts. Prior to enrollment, certain information, such as a list of providers that accept the card and the discounts available, is vital for informed decision making. With respect to provider information, states have similar approaches. Alaska, Montana, and Nevada laws specify that companies must provide access to a list of participating providers and that this information must be available to consumers prior to enrollment. Alaska requires a list of providers in a purchaser’s local area; Nevada requires a list within 50 miles of where a consumer resides; Montana requires a list within 60 miles of where the consumer resides. With respect to access to information about discounts, only Alaska requires companies to make readily available a list of discounts offered by participating providers. Nevada requires a list of services (to be provided to consumers) for which discounts are available. Montana and Utah do not require companies to provide consumers with specific information about the amount of discounts available (but require a list of discounted services to be included in a contract with providers). Lack of this information makes it nearly impossible for consumers to make informed decisions.

States also vary in their approaches to the problem of providers not recognizing or accepting a discount card. For instance, Utah and Nevada require a written contract between a discount card company and a provider or provider network that contracts on behalf of participating providers; a copy of the contract must be filed with the state. Alaska, for example, requires a contract with each provider, while Montana, Nevada, and Utah allow for contracts with networks.

***A requirement to contract directly with providers helps protect consumers against the problem of providers not recognizing the card and the discount (if a provider contracts directly with a discount card company, the provider understands that he or she is promising a discount to enrolled people).***

## **1. Oversight: identification of new problems**

Empowered by the new laws, some states have assigned investigators for “undercover” work. One state reports establishing an undercover office, bank account, mailing address, etc. Investigators look for web-based and other advertisement, go through the enrollment process, review information received from discount cards for compliance with the state’s laws, and then use the investigation to require corrective action and compliance (in some cases through cease and desist and other oversight authority). Others report using under-cover techniques – without a designated unit -- to help identify non-compliance with state laws.

Despite covert and transparent oversight activities, regulators report finding new tactics being used by some individuals to avoid the requirements of the new laws. Some of these tactics include:

- Marketing medical discount products as “association medical plans” or group insurance. Upon close examination, products are discount cards and companies offering them should be licensed or registered, but are not, or should be complying with standards for discount cards, but are not.
- Trying to avoid standards, some are selling discount cards with “blanket” insurance policies. These bundled products include scheduled hospital benefits, doctor office visit benefits, term life insurance (older bundled products include accident emergency room benefits, accident disability benefits, accidental death and dismemberment benefits). These bundled products are sold without using licensed insurance producers.
- Some licensed/registered companies are selling bundled products that include insurance from companies not authorized to do business in the state (a.k.a. unauthorized insurers).
- Some licensed/registered companies are bundling discount cards with health insurance products but without an insurance company (also considered unauthorized insurers).
- When a company is denied registration or licensing, some nonetheless continue to operate without authority.

Regulators also report that many unauthorized entities are based out-of-state (e.g., in Texas and Florida), which makes it more difficult and resource intensive to investigate and shut them down.

## 2. Resources

It is too early to determine whether insurance regulators have the resources needed to effectively oversee the new laws. In many ways, each state’s regulatory framework for discount medical cards reflects the type of resources available to regulate and enforce the law.

Insurance departments in Montana, Utah, Nevada, and Alaska are much smaller than in Florida (Table 1). Had these states asked for form and rate review authority or other requirements that Florida’s law includes, they would also have needed new resources.

**Table 1: Resources -- State Insurance Departments, 2004**

	<b>Alaska</b>	<b>Florida</b>	<b>Montana</b>	<b>Nevada</b>	<b>Utah</b>
State population (approximate)	663,000	17.8 million	936,000	2.4 million	2.5 million
Annual budget (approximate)	\$5.2 million	\$67.3 million	\$3.6 million	\$7.1 million	\$5.9 million
Full time staff people	57	305	48.5	72	82

Source: 2004 NAIC state insurance department resources<sup>130</sup>

It is also too early to tell whether the balance between regulatory burdens and consumer protection reached in Montana, Utah, Nevada, and Alaska will be adequate to protect consumers in those states.

It is difficult to measure the impact of new laws because problems with discount cards continue. Given the fraud and abuse problems that state investigators have found in the past and the growing popularity of discount medical cards, it is important to continue monitoring the market in these states to determine whether the new laws have had their desired effect or whether stronger standards with a full array of problem prevention (form and rate filing reviews) and enforcement tools will be necessary to protect purchasers.

***For policymakers one important question is whether state regulation encourages a market for a product that is valuable to individuals and communities while effectively protecting consumers against a demonstrated abuses and fraud by some in the industry. The tradeoffs between regulation and consumer protection are not unique to the discount medical card industry but exist in every industry selling a consumer product.***

## PART V. RECOMMENDATIONS AND CONCLUSION

In response to widespread fraud and abuse problems, policymakers in Florida and in other states enacted new laws to establish stronger standards for discount medical cards. Florida's legislation established a model for regulating discount medical cards by establishing standards for companies operating such programs and creating standards for products to help prevent problems and protect consumers when problems occur. Some of the most important consumer protections include:

- regulatory oversight tools like licensing companies, which includes full investigations to ensure companies are financially able to conduct business and are operated by qualified people;
- form and rate reviews, which help regulators prevent problems; and
- market conduct examinations, which help to identify, prevent, and correct problems.

Policymakers in other states have also enacted new laws for discount medical cards. Some are similar to Florida's, requiring standards for companies and products. None, however, provides the full range of regulatory oversight tools needed – form and rate reviews and market conduct examinations – to protect consumers before problems occur. Some states, however, include stronger standards for products and companies than applicable in Florida.

Although Florida's law became a model for standards and regulatory framework adopted, in part, by the NAIC, and some of its elements were enacted in other states, there are areas in this law that warrant further investigation and improvement. As this product and market evolve, on-going monitoring will be even more important.

Discount medical cards may become more prevalent and some in the industry see such cards as an important component of the consumer driven health care (CDHC) movement.<sup>131</sup> Some believe that the demand for discount cards will increase as high-deductible health plans become more prevalent. (Generally, high-deductible health plans have PPOs and HMOs, which allow enrollees access to discounted rates prior to reaching their deductible, in which case a discount card would not be needed.) According to Florida's Association of Health Plans, discount medical cards "[a]re an important market segment, and coupled with health insurance, have an

***As consumers continue to rely on discount medical cards (and if this product grows), it is important to address abusive and fraudulent practices by some, and to establish standards to protect residents buying such cards.***

important role in a consumer directed portfolio of products that include high deductible health plans, health savings accounts and HRAs....”<sup>132</sup>

The following are our recommendations to improve protection for Florida’s consumers against fraud and abuse and to improve the product for consumers who rely on discount medical cards either as a supplement or as an alternative to health insurance.

## A. Value of discount cards: transparency, price, discounts & providers

At the OIR public hearing, several suggestions were made to improve the value of discount medical cards to consumers. According to a representative from Blue Cross Blue Shield of Florida, “Despite the need for regulation, DMPOs are an important market segment and serve a *limited* purpose in the marketplace.” (emphasis in the original) He further noted, “Some DMPOs offer concrete benefits to their customers and, if purchased by an informed public, can benefit select segments of consumers. Particularly valuable in my opinion are ... *Discount Medical Plans where consumers can determine upfront their actual cost for services versus the monthly cost for the discount plan* (emphasis added).”<sup>133</sup>

When it comes to discount cards, however, assessing their value to a particular consumer is difficult. Value depends on many factors. These include the price (considering monthly and administrative fees) and the benefits (amount of discount), and convenience of use, such as ease and the time involved in finding participating providers and to travel to their location. To-date, as discussed earlier, problems like high monthly and administrative fees, lower than expected discounts, and difficulty finding providers raise questions about the product’s value. Although some programs may offer real value, due to a lack of transparency, it is difficult for consumers to find and distinguish those from cards that offer no value to them.

***To enable purchasers to make informed decisions, therefore, access to information on participating providers and the specific discount amounts they offer to cardholders is paramount.***

For a product that seeks to bring value to consumers, accurate information about discounts is neither provided prior to enrollment nor prior to receiving a service. And as documented by state investigations, advertised discounts do not always accurately reflect actual discounts.

Even assuming that advertised discounts accurately reflect actual discounts, consumers are faced with the additional problem of determining what the actual value of these discounts are. Two vital questions for policymakers, regulators, and consumers to ask are:

- What is a “retail” price for a service? and
- Whether discounts applied to the “retail” rate provide real savings?

In other words, it is difficult to measure the size of a discount if a provider’s rates vary depending on a patient’s insurance coverage. For instance, a physician may have different rates depending on the type of insurance one has – PPO, HMO, or indemnity (and each insurer may have negotiated different usual and customary rates with physicians). Rates may also be different when a patient is paying cash. It is often unclear what the retail rate is to which the discount applies. And when a discount is off “retail or standard rates,” it is unknown whether any patient is ever charged that “retail” rate. If not, then a discount off a rate that no one pays is not providing any value to consumers. Because the premise of discount medical cards is that people with a card receive discounts for medical care and services, it is important to examine to which rates discounts are applied. Additional research should be conducted looking at these questions, especially for hospital and physician services.

Price transparency is also lacking. When discount medical cards are sold in a package with other products, the price for each benefit is not disclosed to the purchaser (in bundled products). It is difficult to determine which cards might provide the best value for a buyer. In other words, without information on how much of the monthly fee pays for access to a discount for the type of service needed, e.g., dental discounts, a consumer cannot compare the value of cards. For competition and consumerism to work, purchasers must have information about monthly fees and the amount of savings to determine whether there is any value or which card provides the biggest value considering the price to access the discount and the discounted price for a medical service.

Because information accurately and specifically reflecting the amount of discounts is not disclosed and because discount cards are often “bundled” with discounts for other services like accident insurance or discounts for legal fees, it is difficult for consumers to compare and be smart shoppers. Without suitable information (including amount of discount and the monthly fee for accessing that discount) allowing consumers to choose among companies and products, this market is not based on true competition. This is so, of course, because true competition is based on the assumption that all necessary information is available to allow buyers of a product to make rational purchasing decisions.

A goal for policymakers and industry alike should be full price and discount transparency. Florida's Association of Health Plans (FAHP) recognized this earlier this year, stating that it “supports full transparency of health information including full disclosure of DMPO networks and discounts to the consumer.”<sup>134</sup> At the August 2006 OIR public hearing, an insurance company executive also recommended price transparency for DMPOs, noting the need for information on discounts. He reported that there is an existing model in Florida for such information for consumers -- “FloridaCompareCare.gov” is a web site that provides consumers with price information on certain procedures performed at ambulatory centers and in hospitals (charges by procedure by facility).<sup>135</sup> He suggested that disclosure of similar information be required of DMPOs.

In fact, a founding member of CHA, Care Entrée (a subsidiary of a publicly traded company) has issued a report documenting “charges” by providers and the price enrollees paid for each service/procedure. The information is coded using CPT codes.<sup>136</sup>

Additionally, Florida's law already requires contracts between DMPOs and providers (or their networks) to include a fee schedule.

- We recommend that the fee schedule be made available to consumers prior to enrollment to enable them to make more informed purchasing decisions.

## B. Suitability

Some marketers target low and moderate income people, as well as those who cannot afford health insurance. Most discount medical programs require payment to providers at the time of service or care (or in case of hospital discounts, a deposit is required). In other words, a person could not establish a monthly payment plan with a provider and receive the discount promised by the card issuer. This raises a serious question about the ability of low and moderate income families to ever utilize a discount card. Policymakers have stepped in other areas, such as long-term care insurance, when it was clear that a product is not suitable for certain segments of the population. In the case of long-term care insurance, there is a suitability assessment and the sale of the product is restricted.

- We recommend that policymakers should consider the suitability of discount medical cards for persons who cannot afford to pay for a medical service at the time of service (when this is a prerequisite for receiving a discount). Furthermore, there are public insurance and medical programs, e.g., community health centers that provide free or reduced fee care. Instead of using scarce resources for a medical discount card – a product that they would

not receive benefits from -- low and moderate income wage earners should be directed to programs that can help them to access and finance their medical care.

## C. OIR's authority over Florida-based companies selling out-of-state

Regulators and investigators in other states note that some entities that are engaged in illegal activities in their states are based in Florida.

- We recommend that the authority of Florida's regulators be clarified to include jurisdiction over the activities of companies located in Florida, even when such companies do not sell to Florida's residents. This will help deter "bad actors" from establishing operations and "hiding" in Florida.

## D. Cancellation

Florida's policymakers established standards for discount card products including: a right to cancel within 30 days *of enrollment* for a refund of membership fees minus a nominal processing fee (\$30).<sup>137</sup> Other states, like Montana (sometimes cited by industry as a model for regulating this product), requires a refund within 30 days *of card delivery*. Montana's requirement provides consumers with a full month to test a product. The current right to a 30-day cancellation period in Florida does not ensure that new members will have a full 30 days to test a discount card because it takes time to process enrollment and to mail membership information to new members. In some cases, as in the 2003 case investigated by the AG in Florida, consumers may only have a few days to actually use the card before the 30-day cancellation period has expired.<sup>138</sup>

Additionally, some states require a refund of all fees, not just the monthly fees. Cancellation rights are important because they give enrollees an opportunity to test a product, to make sure that promised discounts and benefits actually materialize. A full refund (including administrative one-time fees) also helps to ensure that a consumer who was misled about the product, e.g., enrolling because of a false belief that it is insurance or when discounts are exaggerated, receives a full refund. A discount card operator should not benefit financially, by keeping a partial fee, from a potentially unlawful practice of its marketer.

- We recommend that consumers be given a right to cancel (and test the product) 30 days from delivery of the discount card and program information or the period be extended to 45 days from enrollment and that this right include a full refund (monthly fees and any applicable one-time administrative fees).

## E. Emerging issues in Florida

### 1. Bundling and rates

According to industry, some companies "have unbundled their discount cards in order to avoid compliance with actuarial certification regulations that protect consumers and weed out the illegitimate discount cards from those that offer value."<sup>139</sup> Florida's law states that fees exceeding \$30 per month must be justified and approved. Unbundling for regulatory purposes and then reselling products with fees exceeding \$30 per month appears to be a violation of the letter and the spirit of the law.

- If companies are engaged in these activities, regulators should investigate and require corrective action. If there is confusion, regulators should clarify that unbundling for fee approvals and then bundling upon sale (to exceed \$30) is prohibited by law.

When bundled, rates for discount medical cards should be disclosed to purchasers. For instance, when buying a product that includes a medical card, discounts for legal fees, and accident insurance, the price for the medical discount card should be identified separately from the price for the entire product. This should be the case even when the price for the medical discount card is lower than \$30 per month. Specific price information is necessary for consumers to make informed purchasing decisions.

Some industry representatives expressed a concern that standards for approval from regulators for fees exceeding \$30 per month are vague and that no company has received approval for a higher rate so far. They argue that the requirement and its implementation have been problematic because there is no clear standard that regulators use to grant approval for rates higher than \$30 per month. According to industry representatives, part of the impetus for seeking a legislative change (increasing the threshold for requiring approval to \$60 per month) is the uncertainty over what information they have to submit to receive approval for higher rates.

- We recommend that additional guidance be developed relating to rate approval. However, amending the statute (from \$30 to \$60 safe harbor for no rate approvals) means prices will double. This does not serve the interests of consumers.

## 2. Marketing

To address fraud and abuse problems related to marketing of discount medical cards, some states hold the regulated company accountable for violations of the law by their marketers. This approach encourages companies to be more careful in selecting and training their marketers. Also, because marketers are not required to be licensed insurance agents, standards including training and penalties applicable to licensed agents do not apply to marketers of discount cards.

In Florida, the DMPO is responsible for acts of its marketers “within the scope of the marketers’ agency.” It is uncertain whether the language “within the scope of the marketers’ agency” is sufficient to hold DMPOs accountable for violations of Florida’s laws by marketers. When similar language, “within the scope of their contract,” was proposed in Maryland, the AG’s office expressed concerns that “plans can simply draft their marketing agreements to state that any marketer actions in violation of state and federal laws are ‘outside the scope of the contract,’ which could create a major escape route in terms of plan liability for the actions of their marketers.”<sup>140</sup> In Florida, the liability language has not been tested to determine whether it could be circumvented to allow DMPOs to escape responsibility for the acts of their marketers related to the sale of discount cards, while financially benefiting from wrongful acts.

Other states take a different approach to marketers (and resellers) than that used by Florida. Nevada and Utah require resellers (private label) to also be registered and licensed. Montana requires the DMPO to provide the state with background information on all their resellers and enrollers (and holds DMPOs liable for their acts).

- We recommend that regulators closely monitor marketing through both consumer complaints and through its market conduct examinations. Regulators should assess whether under current law DMPOs can be held accountable for violations of the law by their marketers. And if not, then the statute should be amended to address any on-going problems with marketers circumventing Florida’s consumer protections, e.g., misleading consumers that the product is health insurance.

### **3. Carve-out from Florida's law for discount medical cards that do not provide discounts for physician and hospital services**

When we began this research, we had assumed that reported problems were solely related to cards that provided physician and hospital services discounts.<sup>141</sup> However, upon examination of administrative and court cases, investigations by AGs and state insurance regulators, and media reports, that assumption turned out to be not supportable. Rather, the problems that we have been able to identify are not unique to cards for physician and hospital discounts. Additionally, the first three final market conduct examinations by insurance regulators in Florida focused on dental discount cards and showed violations of the law related to these products.

- We recommend continuing the application of consumer protections and standards to discount medical cards currently subject to the law. We also recommend examining prescription drug discount cards to assess the need to include them in existing protections and standards.

### **4. Reporting problems with fraudulent and unlicensed DMPOs**

According to consumer complaints, most problems reported to regulators relate to unlicensed entities. Also, some regulated companies find problems with other licensed companies and with unlicensed entities and report those to regulators.

- To further encourage reporting of problems by industry, we recommend appointing a contact person in OIR for insurance agents, DMPOs, and others in the regulated community to call or contact in writing to report potentially unlawful activities. We also recommend public posting of status information about investigations (e.g., "under investigation" or "investigation closed").<sup>142</sup> This information will inform the regulated community that their information is being appropriately acted upon and will inform the public about the program in which they are considering enrollment.

## **Conclusion**

There have been widespread fraud and abuse problems with discount medical cards reported by consumers and found by state and federal civil and criminal investigators nationwide. The most common problems identified by AG offices, as well as state insurance regulators and investigators interviewed, include: consumers believe or are told they are buying insurance; small or no discounts; few or no participating providers; problems canceling enrollment; and fraud. Such problems have also affected many consumers in Florida. In 2003, Florida's insurance regulators received nearly 1000 consumer complaints related to different types of discount medical cards.

Policymakers and regulators in Florida and in other states have taken important first steps to address fraud and abuse. Florida's legislature passed a landmark law setting a standard for the rest of the country. Many of Florida's standards were enacted by other states and more recently Florida's law became the blueprint for a model law adopted by the National Association of Insurance Commissioners. Along with effective oversight strategies by regulators and investigators, the high standards in the law have resulted in fewer consumer problems and better protection against fraud and abuse. These have also made discount medical cards potentially more valuable for users in Florida.

As more consumers rely on medical discount cards, the need to ensure suitable consumer protections and to improve existing standards will also grow. Given the history of abusive practices by some card marketers and issuers that have injured consumers and left some card purchasers uninsured and uninsurable, it is important for policymakers to examine existing consumer protections and find ways to improve them.

## ENDNOTES

1. Testimony, Richard Robleto, Deputy Commissioner, Florida Office of Insurance Regulation, *Current State of Discount Medical Plan Organizations (DMPOs) in Florida*, Public Hearing, Office of Insurance Regulation, August 25, 2006 (hereinafter "Robleto Testimony 2006").
2. *State of Texas v. International Association of Benefits, F/K/A International Association of Businesses A/K/A IAB*, Plaintiff's Original Petition, District Court of Dallas, Texas, 2005 (hereinafter "Texas v. IAB, Plaintiff's Petition"); *State of Texas v. International Association of Benefits, F/K/A International Association of Businesses A/K/A IAB*, No. DV.-0504134-J, Agreed Final Judgment and Permanent Injunction, District Court of Dallas, Texas, 2006 (hereinafter "Texas v. IAB, Final Judgment").
3. testimony, Nick Iarossi, Government Consultant, Capital City Consulting, Representing Consumer Health Alliance (CHA), *Current State of Discount Medical Plan Organizations (DMPOs) in Florida*, Public Hearing, Florida Office of Insurance Regulation, August 25, 2006 (hereinafter "Iarossi Testimony").
4. Kofman, M., Libster, J., & Bangit, E., *Discount Medical Cards: Innovation or Illusion?* The Commonwealth Fund, March 2005, p. 2 (hereinafter "Kofman, *Discount Medical Cards*"); Britton, G., *Discount Medical Plans and the Consumer: Health Care in a Regulatory Blind Spot*, *Loyola Consumer Law Review*, 2004, Volume 16 (2), p. 109-110 (hereinafter "Britton, *Discount Medical Plans*").
5. *Care Entree Releases First-of-Its-Kind Discount Medical Plan Repricing Data Report*, PR Newswire US, May 8, 2006 and pdf report (copy available from authors) (hereinafter "Medical Plan Repricing Data Report").
6. Ditsler, E., Fisher, P., & Gordon, C., *On the Fringe: The Substandard Benefits of Workers in Part-time, Temporary and Contract Jobs*, The Commonwealth Fund, December 2005, p. 4 (hereinafter "Ditsler, *On the Fringe*").
7. *In the Matter of US Capital HealthCard Bft Inc., d/b/a Chamber Health and US HealthCard, Chamber of Commerce Association, Inc., d/b/a Chamber of Commerce Association and Greater New York Chamber of Commerce, Myer Gutnick, Samuel J. Eisenberg, and Mendy Farro, Inc.*, Assurance of Discontinuance, New York Attorney General, June 2002, p. 8 (hereinafter "US Capital HealthCard, Assurance of Discontinuance"); *Federal Trade Commission v. Platinum Health Plus, LLC et. al.*, Case No. 05-22465, Complaint for Permanent Injunction and other Equitable Relief, United States District Court for the Southern District of Florida, September 8, 2005, p. 4 (hereinafter "FTC v. Platinum Health, Complaint").
8. *FTC Continues Crackdown on Scams Aimed at Hispanics: Hispanic Law Enforcement and Outreach Forum Held in Los Angeles*, Press Release, Federal Trade Commission, October 25, 2005, (available at [www.ftc.gov/opa/2005/10/losangeles.htm](http://www.ftc.gov/opa/2005/10/losangeles.htm)). See also, *FTC v. Platinum Health*, Complaint, p. 3 (defendants "solicited Spanish-speaking consumers throughout the country to purchase the Platinum Health Plus medical discount program."). See also, *Federal Trade Commission v. Remote Response Corporation et. al.*, Complaint for Injunctive and Other Equitable Relief, Civ. 06-20168, United States District Court, Southern District of Florida (filed January 23, 2006) (hereinafter "FTC v. Remote Response Corporation, Complaint"). On February 15, 2006, a U.S. Federal District Court issued an injunction and froze assets of defendants. *Federal Trade Commission v. Remote Response Corporation, et. al.*, Stipulated Preliminary Injunction with Asset Freeze, Appointment of Permanent Receivers, and Other Equitable Relief, Civ 06-20168, United States District Court, Southern District of Florida (Feb 15, 2006) (hereinafter "FTC v. Remote Response Corporation, Stipulated Preliminary Injunction").
9. *Discount Health Plans Crack Down by State Stops False and Misleading Advertising*, News Release, Department of Managed Health Care, January 5, 2005, (Florida-based Platinum Health Plus was ordered to "stop offering deceptive discount health cards to Latino consumers"); *In the Matter of: Platinum Health Plus, LLC*, Cease and Desist Order and Notice of Right to Hearing, DMHC No.: 04-265, Department of Managed Health Care of the State of California, Filed Sep. 22, 2004, p. 2 (hereinafter "*In the Matter of Platinum Health, Cease and Desist Order*"); *Commissioner Praeger and Attorney General Kline Unite to Fight Fraud, Marketing and Program Guidelines for Medical and Prescription Discount Cards*, New York State Attorney General's Office, 2004, available at [http://www.oag.state.ny.us/health/discount\\_cards\\_guidelines.html](http://www.oag.state.ny.us/health/discount_cards_guidelines.html).
10. Skidmore, S., *Affordable Health Told to Cease Operations; Promised Discounts Not Provided, State Says*, The San Diego Union-Tribune, April 19, 2005. One entity targeted low-income Spanish-speaking residents.
11. *Gallagher Files Charges Against Two Sarasota Agents For Misleading Elderly in Home Health Care Plan Sales*, Press Release, Florida Department of Financial Services, June 1, 2006, available at [www.fldfs.com/pressoffice](http://www.fldfs.com/pressoffice); (Independent Living Home Care Membership Association offering access to providers of home medical care services enrolled people mostly in their 80s and 90s who believed they were purchasing coverage for such services not discounts); *Consumer Alert: Be Aware of Health Plan Scams and Learn How to Protect Yourself*, Alaska Department of Community and Economic Development, August 23, 2004; *Discount Health Fraud*, Channel 3 News, KVBC, Las Vegas, NV., February 7, 2006, available at [www.kvbc.com/Global/story.asp?S=3917764&nav=15MV](http://www.kvbc.com/Global/story.asp?S=3917764&nav=15MV) (news story on Nevada Health Care Network that provided for access to discounted dental care for hundreds of seniors in Nevada). In 2004, the Maryland

Insurance Administration issued a report on discount cards, in part based on a joint public hearing it had with the Maryland Attorney General's Office. At the hearing Maryland's Department of Aging, Program Director of the Senior Health Insurance Assistance Program testified that seniors who buy the Medicare prescription drug cards may not understand what they are buying or may be eligible for free medicine through state programs. Representatives from AARP and other seniors groups testified also. It is not clear whether their concerns were related only to Medicare cards or also included non-Medicare prescription drug cards. See *Report of the Maryland Insurance Commissioner Regarding Discount Card Plans*, Maryland Insurance Administration November 18, 2004.

12. J. Joseph Curran, Jr., Attorney General, State of Maryland Office of the Attorney General, Letter to Senate Finance Committee Chairman Middleton, Annapolis, Maryland Office of the Attorney General, April 7, 2005, p. 1.
13. *In the Matter of Platinum Health*, Cease and Desist Order, p. 5. This order was reinstated on Feb. 24, 2005 after the company violated its agreement with regulators to correct its practices, to seek pre-approval of advertising and forms, and for other violations. *In the Matter of: Platinum Health Plus, LLC*, DMHC No.: 04-265, Order Reinstating Cease and Desist Order and Terminating Its Suspension: Notice of Right to Hearing, Department of Managed Health Care of the State of California, Filed Feb. 24, 2005.
14. Power point presentation submitted by Florida Association of Health Plans, Inc, *Current State of Discount Medical Plan Organizations (DMPOs) in Florida*, Public Hearing, Office of Insurance Regulation, August 25, 2006 (available at <http://www.floir.com/DMPOHearing/index.htm>) (hereinafter FAHP Presentation).
15. The fourteen states included Alabama, Arkansas, Connecticut, Indiana, Maine, Missouri, Nebraska, Oklahoma, South Carolina, Tennessee, Texas, Utah, Washington, and Wyoming. *Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, United States General Accounting Office, GAO-04-213, February 2004, p. 40.
16. Ditsler, *On the Fringe*, p. 7. Florida case information (in box) from Pam White, Florida Department of Financial Services, July 19, 2006 Email (hereinafter "White, July 19, 2006 Email").
17. Testimony, Paula Wolf, Consumer, *Current State of Discount Medical Plan Organizations (DMPOs) in Florida*, Public Hearing, Office of Insurance Regulation, August 25, 2006 (hereinafter "Wolf Testimony"); Paula Wolf, documentation of problems with Smart Choice Health Care, November 22, 2005 (telephone conversation with "Tracey") (copy available from authors).
18. Wolf Testimony.
19. Rapaport, L., *Health Card Alert: Promised Discounts May Not Materialize*, Sacramento Bee, March 4, 2005, Business Section, p. D1.
20. Bernstein, A. & Weber, J., *They Think They're Insured. They're Not*, BusinessWeek Online, December 26, 2005, available at [http://www.businessweek.com/magazine/content/05\\_52/b3965064.htm](http://www.businessweek.com/magazine/content/05_52/b3965064.htm)
21. Pollitz, K. et al. *Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes*, Georgetown University Health Policy Institute and American Diabetes Association, February 8, 2005, p. 49.
22. Guaranteed-issue laws vary among states. Kofman, M. and Pollitz, K., *Health Insurance Regulation by the States and the Federal Government: A Review of Current Regulation and Proposals for Change*, Journal of Insurance Regulation, Vol. 24, Issue No. 4, Summer 2006, p. 79-80. In many states, people with medical needs (even minor ones) are denied coverage in the individual market even when they can afford the premiums. Pollitz, K., Sorian, R., & Thomas, K., *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect-health? Kaiser Family Foundation*, June 2002. A federal law -- the Health Insurance Portability and Accountability Act (HIPAA) -- specifically requires insurers to guarantee issue individual insurance coverage to certain qualified individuals (in the alternative, access rights may be implemented through a state high-risk pool). To qualify, an individual must have had 18 months of continuous coverage (without a 63-day break), the most recent coverage must be through a group health plan (job-based insurance), may not be eligible for other coverage, Medicare, or Medicaid, and must take and exhaust COBRA if eligible for it. See also, *Summary of Key Consumer Protections in Individual Health Insurance Markets*, Georgetown University Health Policy Institute, April 2004, available at <http://www.healthinsuranceinfo.net>.
23. *State of Texas v. The Capella Group, Inc D/B/A Care Entrée; Equal Access Health, Inc., D/B/A Health Benefits of America, E A H, EA Health, Equal Health, Equal Health.com, H B A & Associates, Health Care for the Entire Family*, Plaintiff's Original Petition, District Court, Travis Co., Texas, p. 9-10 (hereinafter "Texas v. The Capella Group, Plaintiff's Original Petition").
24. Wojcik, J., *Discount Cards May Find Wider Appeal as Health Care Cover Changes*, Crain Communications Inc., Business Insurance, p. 11, Feb. 28, 2005. In response to what states are considering legislatively, Terri Tullo, president of New Benefits Inc., goes on to say "They're all heading toward what Florida has done," and adds "but I think it's good for the industry."
25. Horvath, S., *Florida Law Reins in Health Discount Cards*, Business Palm Beach Post, March 27, 2005, p.1F.
26. Kofman, *Discount Medical Cards*, p. 4.
27. *In the Matter of Smart Health Care Solutions*, IN2407128/PEG, Cease and Desist Order and Notice of Right to Hearing, State of Minnesota Commissioner of Commerce, May 11, 2005, p.1; *In the Matter of United*

- Family HealthCare Group*, Case No. 2004-36, Temporary Cease and Desist Order, Notice of Proposed Agency Action and Opportunity for Hearing, State Auditor's Office, Insurance Department of Montana, 2004; *Are You Covered?* KOLO News Channel 8. November, 2005 (hereinafter "KOLO News, *Are You Covered*").
28. Roy Cooper, Attorney General v. National Healthcare Association, LLC, Complaint for Temporary Restraining Order, North Carolina, County of Wake, Superior Court Division, Filed September 2005, p. 3. Defendants in this case failed to respond and appear in court. The Attorney General's office subsequently filed for a permanent injunction. Roy Cooper, Attorney General v. National Healthcare Association, LLC, Complaint for Temporary Restraining Order, North Carolina, County of Wake, Superior Court Division, Filed October 3, 2005 (hereinafter "*Cooper v. National Healthcare Association*, October 2005 Complaint"). A state judge ordered an "Entry of Default." Roy Cooper, Attorney General v. National Healthcare Association, LLC, File No. 05-CVS-12969, Entry of Default, North Carolina, County of Wake, Superior Court Division, December 5, 2005. This case has not been settled or resolved as of the date of this report.
  29. US Capital HealthCard, *Assurance of Discontinuance*. p.12.
  30. KOLO News, *Are You Covered*.
  31. Illinois v. International Association of Businesses d/b/a IAB, International Association of Benefits, et al., # 05 CH 06785, Complaint, Circuit Court of the Cook County Judicial Circuit, Filed April 18, 2005 (hereinafter "*Illinois v. IAB*, Complaint"). This case was recently settled. Similar to the settlement with the Texas Attorney General's Office, IAB agreed to change many of its marketing and business practices. See Illinois v. International Association of Businesses d/b/a IAB, International Association of Benefits, et al., # 05 CH 06785, Consent Decree, Circuit Court of the Cook County Judicial Circuit, July 31, 2006 (hereinafter "*Illinois v. IAB*, Consent Decree").
  32. *Texas v. The Capella Group*, Plaintiff's Original Petition, p.6-7.
  33. *In the Matter of National Association of Preferred Providers/Family Care*, Assurance of Discontinuance, New York Attorney General, March 2004, p. 7.
  34. *FTC v. Platinum Health*, Complaint.
  35. HCC Association Advertisement. <http://www.hccassociation.org/map.aspx>. Retrieved on July 12, 2006.
  36. Kofman, *Discount Medical Cards*, p. 3.
  37. Maze, J., *Some Medical Discount Cards May Be Unhealthy For Wallet*, The Post and Courier. Charleston, SC. October 7, 2004.
  38. *Texas v. IAB*, Plaintiff's Petition, p. 6.
  39. For a summary of state actions finding smaller than promised discounts see Attachment A. See also, In Re: American Benefits Association, Assurance of Discontinuance, Maryland Attorney General, October 2003; *Cooper v. National Healthcare Association*, October 2005 Complaint.
  40. *Texas v. The Capella Group*, Plaintiff's Original Petition, p 10-11. California's Department of Managed Health Care also issued a Cease and Desist Order against this company in part for "misleading California consumers and misrepresenting its product." The order went on to say "[i]t [the company] purports to provide a discount on health care services but no discounts are available unless the member established an escrow account and has sufficient funds in the escrow account with an affiliated company of the Respondent to pay for the medical service on or before said service is rendered." In the Matter of The Cappella Group, Inc. d/b/a Care Entrée, Before the Department of Managed Health Care of the State of California, DMHC No 04-312; Cease and Desist Order and Notice of Right to Hearing, Filed July 15, 2005, p. 2.
  41. *Texas v. The Capella Group*, Plaintiff's Original Petition, p. 11.
  42. Id. at p. 12.
  43. *In the Matter of Medisavers, Inc.* Assurance of Discontinuance, New York Attorney General, July 2002, p. 6 (hereinafter "*Medisavers, Inc.*, Assurance of Discontinuance").
  44. *In the Matter of MedAdvantage L.L.C.*, Assurance of Discontinuance Pursuant to Executive Law Section 63, Subdivision 15, New York Attorney General, 2003, p.7 (hereinafter "*MedAdvantage*, Assurance of Discontinuance").
  45. Kofman, *Discount Medical Cards*, p. 5.
  46. Testimony, Holly Whelan, Manager, Public Policy, American Diabetes Association, *Current State of Discount Medical Plan Organizations (DMPOs) in Florida*, Public Hearing, Office of Insurance Regulation, August 25, 2006.
  47. *Medisavers, Inc.*, Assurance of Discontinuance, p. 7.
  48. *MedAdvantage*, Assurance of Discontinuance, p. 8.
  49. *In the Matter of: Equal Access Health, Inc./Health Benefits of America*, DMHC No.: 04-377, Cease and Desist Order an Notice of Right to Hearing, Department of Managed Health Care of the State of California, Filed July 15, 2005, p. 2 (hereinafter "*Equal Access Health*, Cease and Desist Order, California"); See also *In the Matter of Platinum Health*, Cease and Desist Order, p. 2.
  50. *Medisavers, Inc.*, Assurance of Discontinuance, p. 9.
  51. *State of Texas v. American Arc Management Corporation et. al.*, No. 2005-29464, Plaintiff's Original Verified Petition and Application for Ex Parte Temporary Restraining Order, Temporary Injunction and Permanent Injunction, District Court, Harris Country TX, p. 9 (hereinafter "*Texas v. American Arc Management*

- Corporation, Petition.”); *State of Texas v. American Arc Management Corporation et. al.*, No. 2005-29464, Agreed Final Judgment, District Court, Harris Country TX, July 29, 2005 (hereinafter “*Texas v. American Arc Management Corporation, Agreed Final Order*”); *Texas v. IAB*, Plaintiff’s Petition, p. 5; *Equal Access Health, Cease and Desist Order, California*, p. 7.
52. Stephanie Horvath, Palm Beach Post, “Florida Law Reins in Health Discount Cards” Business Pg 1F. March 27, 2005.
  53. *In the Matter of: United Family Healthcare Group, Before the Department of Managed Health Care of the State of California*, DMHC No.: 04-374, Cease and Desist Order an Notice of Right to Hearing, Filed July 15, 2005, page 5 (hereinafter “*United Family Healthcare Group, Cease and Desist Order, California*”); *Equal Access Health, Cease and Desist Order, California*.
  54. *Texas v. The Capella Group*, Plaintiff’s Original Petition, p 9-10.
  55. *Medisavers, Inc.*, Assurance of Discontinuance, p. 10.
  56. Kansas Insurance Department, Press Release: Commissioner Praeger and Attorney General Kline Unite to Fight Fraud, July 1, 2004.
  57. Cease and Desist Order D 05-13. To: Signature Health Group. State of Alaska Department of Commerce, Community, and Economic Development, Division of Insurance, July 2005; KOLO News, *Are You Covered; In the Matter of United Family HealthCare Group*, Case number 2004-36. Temporary Cease and Desist Order, Notice of Proposed Agency Action and Opportunity for Hearing. State Auditor’s Office, Insurance Department of Montana, 2004
  58. Kofman, *Discount Medical Cards*, p. 5.
  59. *In the Matter of: Ameriplan USA Corporation et al*, Case No. 04-03-06-212-I Notice of Proposed Agency Disciplinary Action and Opportunity for Hearing, Before the State Auditor and Commissioner of Securities and Insurance, Montana, July 2006, p. 4. This case was recently settled. *In the Matter of: Ameriplan USA Corporation et al*, Case No. 04-03-06-212-I, Consent Agreement, Before the State Auditor and Commissioner of Securities and Insurance, Montana, October 2006 (available at <http://sao.mt.gov/legal/insurance/insurance06.asp>). Ameriplan was fined \$200,000 for not having contracts with providers who would honor the discounts. The company also agreed to establish a restitution fund for Montana consumers who purchased the cards. *Texas Firm Fined for Selling Bogus Medical Discount Cards*, Associated Press, October 25, 2006.
  60. *Medisavers, Inc.*, Assurance of Discontinuance, p. 8.
  61. *State of Florida, Department of Legal Affairs, Office of the Attorney General vs. Memberworks, Inc.* Case No.: 03-9797, Amended Complaint for Permanent Injunctive Relief, Circuit Court of the 13<sup>th</sup> Judicial Circuit, Hillsborough Co, Florida, October 2003, p. 18 (hereinafter “*Office of the Attorney General v. Memberworks, Amended Complaint*”). At the time of our earlier study, Memberworks Inc. owned a company that provided the discounted benefits for one of the five cards we enrolled and tested. The card was the only one that achieved 100% provider recognition and discounts were in the range advertised.
  62. *FTC v. Platinum Health*, Complaint.
  63. *Office of the Attorney General v. Memberworks*, Amended Complaint, p. 16-17.
  64. *Texas v. IAB*, Plaintiff’s Petition, p. 5.
  65. *Equal Access Health*, Cease and Desist Order, California, p. 6.
  66. *United Family Healthcare Group*, Cease and Desist Order, California, p.6.
  67. *Request for Amendments of SB281, Quotes from Consumers Who Filed Complaints Against Sellers of These Plans*, State of Maryland Office of the Attorney General, Consumer Protection Division (information provided to the Maryland General Assembly by the Attorney General’s Office in 2006).
  68. *FTC v. Platinum Health, Complaint*, p. 5-6. Within 8 days of the law suit filing, defendants agreed to a consent order without admission of guilt. *Federal Trade Commission v. Platinum Health Plus, LLC, FIESTA Marketing, LLC, Telemedia, LLC, Michael P. Garcia, and Alexander R. Garcia*, Civ 05-22465, Consent Decree, United States District Court, Southern District of Florida, (filed September 16, 2005). The federal court ordered defendants to stop representing the discount medical program as insurance and misrepresenting refund policy. *Id.*
  69. Kofman, *Discount Medical Cards*, p. 6.
  70. White July 19, 2006 Email.
  71. *Texas v. The Capella Group*, Plaintiff’s Original Petition, p. 9.
  72. For background information on phony health insurance, see Kofman, M. Lucia, K., & Bangit, E., *Proliferation of Phony Health Insurance: State and Federal Government Respond*, The Bureau of National Affairs, Fall 2003 (hereinafter “*Kofman, Proliferation of Phony Health Insurance*”). (Information about discount cards being used as a subterfuge in the report at p. 15-16.)
  73. *Miami Man Arrested for Selling Bogus Discount Plan*, Press Release, Florida Division of Financial Services Press Office, October 15, 2004.
  74. “Discount Health Fraud” News, February 7, 2006 available at [www.kvbc.com/Global/story.asp?S=3917764&nav=15MV](http://www.kvbc.com/Global/story.asp?S=3917764&nav=15MV) (news story on the Nevada Health Care Network whose operator was involved in a drug importation business where medication was coming from India).

75. *Office of the Attorney General v. Memberworks*, Amended Complaint, p. 11.
76. *Id.* at p.14-15.
77. State of Alaska Department of Commerce, Community and Economic Development: Division of Insurance, Cease and Desist Order D 05-10 To: International Association of Benefits, May 2005.
78. US Capital HealthCard, *Assurance of Discontinuance*, p. 8.
79. *In the Matter of American ARC Management Corporation dba Family Health*, First Amended Cease and Desist Order, Department of Managed Health Care of the State of California, December, 2004, p. 5.
80. *Office of the Attorney General v. Memberworks*, Amended Complaint.
81. US Capital HealthCard, *Assurance of Discontinuance* p. 9-10; *In the Matter of Prudent Choice, Stephen T. Cook*, Case No: 2006-31, Temporary Cease and Desist Order, Notice of Proposed Agency Action and Opportunity for Hearing, State Auditor's Office, Insurance Department of Montana, December 2006, p. 2.
82. Consumer Health Alliance web page, available at <http://www.consumerhealthalliance.org>, visited September 12, 2006.
83. Many states provide consumers with a private right of action under their consumer protection laws. This means that if a consumer can afford a lawyer, the consumer can sue the discount card program. Such suits are rare. We found two. Both in California – one filed by a legal aid office and another filed by “California Foundation for Business Ethics.” The two cases were removed to federal court and consolidated. *Manuela Zermeno, California Foundation for Business Ethics, Inc. et al v. Precis, d/b/a Care Entrée*, No. CV 03-6974 SJO (MANx) and No. CV 03-6997 SJO (MANx) Consolidated, Order Denying Defendants’ Motion to Dismiss, US District Court, Central District of California, Western Division, May 10, 2004. Settlement was reached with each plaintiff. *California Foundation for Business Ethics, Inc. et al v. Precis*, No. CV 03-6974 SJO (MANx), Stipulated Injunction, September 20, 2004 and *Zermeno v. Precis et al*, No. CV 03-6974 SJO (MANx), Stipulated Injunction, October 7, 2004 (copies available from authors).
84. *Texas v. IAB Plaintiff’s Petition*; *Texas v. The Capella Group*, Plaintiff’s Original Petition; *Texas v. American Arc Management Corporation*, Petition.
85. See *Pennsylvania v. Peoples Benefit Services, Inc.*, Complaint in Equity, Commonwealth Court of Pennsylvania, M.D. 2005 (this case involved a prescription drug card and sale of such cards related to Medicare Part D).
86. See *Illinois v. IAB*, Complaint.
87. See *North Carolina v. National Healthcare Association, LLC*, File No. 05 CVS 012969, Preliminary Injunction, North Carolina County of Wake General Court of Justice Superior Court Division, October 3, 2005.
88. See State of Florida, Department of Legal Affairs, Office of the Attorney General vs. Memberworks, Inc. Case No.: 03-9797, Stipulated Settlement Agreement, Circuit Court of the 13th Judicial Circuit, Hillsborough Co, Florida, Summer 2004; MWI Will Pay \$1 Million to Settle Florida Suit, [consumeraffairs.com](http://consumeraffairs.com), July 1, 2004, available at [http://findarticles.com/p/articles/mi\\_km3609/is\\_200407/ai\\_n8625043](http://findarticles.com/p/articles/mi_km3609/is_200407/ai_n8625043); *Texas v. American Arc Management Corporation*, Agreed Final Order; *Illinois v. IAB*, Consent Decree, *US Capital HealthCard*, *Assurance of Discontinuance*; *Texas v. IAB*, Final Judgment.
89. In addition to actions discussed earlier, see *Assurance of Discontinuance*, Consumer Protection Division, The Office of the Attorney General of Maryland, In Re: American Benefits Association (James Shevlin), October 2003; *Healthcare Discounter Agrees to Advertising Changes*, Press Release, Idaho Attorney General’s Office, December 12, 2003.
90. State of Alaska, Department of Commerce, Community, and Economic Development, Division of Insurance, Cease and Desist Order D 05-10, Order against International Association of Benefits, Dallas, Texas (May 2005) (order alleges violations for selling insurance without a proper license and other violations related to producer licensing and sale of insurance); State of Alaska, Department of Commerce, Community, and Economic Development, Division of Insurance, Cease and Desist Order D 05-13, Order against Signature Health Group, Deerfield Beach, Florida (July 2005) (based on selling insurance without a proper license and other violations related to producer licensing and sale of insurance). Regulators alleged that the company led an Alaskan consumer to believe that she was buying health insurance. They also alleged that the company falsely claimed that a medical clinic and pharmacy the consumer used were covered under the plan. *Id.* at 2.
91. Prior to these laws, some states had notice-registration laws, which were not adequate in protecting consumers and preventing problems.
92. Due to resource issues in other states, the model also include “less” resource intensive options, meaning less protections for consumers.
93. FL. Stat. §§ 636.002-636.244 et seq.(2006).
94. FL. Stat. § 636.205(1)( c) (2006).
95. A companion requirement for DMPOs is to maintain a web site, on which current provider information must be posted.
96. A DMPO is not permitted to make members wait a period of time after enrollment before receiving access to discounts.

97. One reason for this last requirement is that, in the past, some entities would not provide accurate contact information to members, leaving consumers and investigators without any means of accurately identifying and locating the entity in case of misrepresentation or other problems.
98. FL. Stat. § 636.228 (2006).
99. FL. Stat. § 636-216(4) (2006).
100. According to information provided by the Office of Insurance Regulation, the average review time is 14 days. *Discount Medical Plan Organizations (DMPOs)*, Florida Office of Insurance Regulation, p. 75.
101. FL. Stat. §636.206(1) (2006).
102. Robleto Testimony 2006.
103. *Discount Medical Plan Organizations (DMPOs)*, Office of Insurance Regulation, Florida, p. 71.
104. This estimate does not include cases that were not tracked as DMPOs prior to 2005.
105. *Summary of Findings From Market Investigations*, Office of Insurance Regulation, August 2006 distributed on August 25, 2006 at the Public Hearing on DMPOs in Miami, FL.
106. Kofman, *Proliferation of Phony Health Insurance*.
107. *Filing: 06-05952*, Florida Department of Financial Services, 2006.
108. Robleto Testimony 2006.
109. *Filing: 06-07414*, Florida Department of Financial Services, 2006.
110. US Capital HealthCard, *Assurance of Discontinuance*, p. 5, 9, 13-14; *Medisavers, Inc.*, *Assurance of Discontinuance*, p. 9.
111. *Market Conduct Final Examination Report of Aetna Life Insurance Company as of December 1, 2005*, Financial Services Commission, Florida Office of Insurance Regulation, Market Investigations (final report released September 2006); *Market Conduct Final Examination Report of Compbenefits Company as of November 3, 2005*, Financial Services Commission, Florida Office of Insurance Regulation, Market Investigations (final report released September 2006); *Market Conduct Final Examination Report of Starmark Benefits, Inc. as of December 9, 2005*, Financial Services Commission, Florida Office of Insurance Regulation, Market Investigations (final report released September 2006).
112. Testimony, Seth M. Phelps, Assistant General Counsel, Blue Cross Blue Shield of Florida, "Discount Medical Plan Summary Comments," p. 2, *Current State of Discount Medical Plan Organizations (DMPOs) in Florida*, Public Hearing, Office of Insurance Regulation, August 25, 2006 (hereinafter "Phelps Testimony 2006") (available at <http://www.floir.com/DMPOHearing/index.htm>); FAHP Presentation.
113. Phelps Testimony 2006.
114. Phelps Testimony 2006.
115. FAHP Presentation.
116. CHA's membership includes 12 companies, 5 of which are licensed as DMPOs in Florida. Member companies are among some of the largest in this industry.
117. *Jeb Bush, Governor, State of Florida, Letter to Sue Cobb, Secretary of State, vetoing HB 1361*, June 27, 2006, p. 2.
118. Mont. Code Ann. § 33-38-101 *et seq.* (2005).
119. See also Medical Care Discount Card Application for Certificate of Registration, State of Montana.
120. Utah Code Ann. § 31A-8a-101 *et seq.* (2005).
121. Written material, including advertising and marketing material, must include the company's name and location and must explicitly disclose that the plan is not insurance, that not all health care providers participate in the plan, that the customer is responsible for all health care bills.
122. Nev. Rev. Stat. § 695H.010 *et seq.* (2005).
123. *Changes to the Alaska Insurance Laws*, Bulletin B 05-08, Alaska Department of Commerce, Division of Insurance, September 28, 2005. Ak. Stat. §21.36.010 *et seq.* (2005).
124. Alaska Stat. 21.36.030(b)(2005).
125. Cal. Health & Safety Code § 1340 *et seq.* (2005).
126. Cal. Health & Safety Code § 1345(f) (2005).
127. In the Matter of the Cease and Desist Order Issued to: The Capella Group, Inc, d/b/a Care Entrée, DMHC No: 04-312, OAH No: N2005-10-0840, Filed September 26, 2006.
128. See *List of all Licensed Plans*, Department of Managed Health Care, September 8, 2006. Researchers sought to interview regulators and attorneys for DMCH but calls were not returned. Researchers were not able to determine how many companies in fact have initiated licensing. It is also not known whether additional charges have been filed against companies that failed to comply with their consent orders.
129. Nev. Rev. Stat. Ann. 695H.170(6) and (7) (2006) requires a right to cancel but does not specify how long a member would have to exercise that right.
130. See Population (per Census for 2005) at <http://www.census.gov/population>.
131. Stanek, S., *States Move to Restrict Medical Discount Cards*, The Heartland Institute, April 1, 2005.
132. FAHP Presentation.
133. Phelps Testimony 2006 p. 3.
134. FAHP Presentation.

135. Testimony, Harry Spring, Humana, *Current State of Discount Medical Plan Organizations (DMPOs) in Florida*, Public Hearing, Office of Insurance Regulation, August 25, 2006.
136. *Medical Plan Repricing Data Report*.
137. If fee exceeds \$30, then the remainder must be refunded upon proper cancellation.
138. *Office of the Attorney General v. Memberworks*, Amended Complaint, p.18.
139. FAHP Presentation.
140. *Subject: SB 281 – Comments regarding amendment proposals of CHA and NAPD*, Office of the Attorney General, Consumer Protection Division, Memorandum to the Senate Finance Committee from Paula Carmody, Assistant Attorney General, February 20, 2006, p. 4.
141. Some in the industry note that most problems with discount medical cards have been related to cards providing discounts for physician and hospital services and that dental or vision cards for example have not had such problems.
142. State criminal justice agencies have constitutional constraints on the type of information that can be made public. Some investigations could lead to criminal actions and therefore, cannot be disclosed (while investigated). An agency may not publicly comment on the status of ongoing criminal investigations.

**ATTACHMENT A: Summary of State Actions in Alaska, California, Florida, Illinois, Minnesota, Montana, New York, and Texas and Actions by the Federal Trade Commission (FTC)**

COMPANY NAME	INDIVIDUALS	ALASKA: SUMMARY OF ALLEGATIONS	DATE/ACTION
International Association of Benefits (IAB)	*	<p><i>Texas-based company</i></p> <p>Sale of insurance without a license                      False advertising</p> <ul style="list-style-type: none"> <li>On website and in brochure, claimed membership included insurance</li> </ul> <p>Enrolled consumer in program and withdrew funds from debit account without consumer's consent</p>	<p>May 2005</p> <p>C &amp; D</p>
Signature Health Group	*	<p><i>Florida-based company</i></p> <p>Sale of insurance without a license</p> <ul style="list-style-type: none"> <li>Claimed that accidental death and dismemberment benefits were included in plan</li> </ul> <p>False advertising</p> <ul style="list-style-type: none"> <li>Used terminology that would indicate the sale of insurance</li> <li>During a phone solicitation, failed to state that the product was not insurance</li> <li>Also during a phone solicitation, indicated that customer's chosen providers accepted the plan; in fact, specified providers were not among the plan's network of providers</li> </ul> <p>Failed to comply with state-mandated health discount card refund policy</p> <ul style="list-style-type: none"> <li>Refunds provided only if membership was terminated within 3 business days of purchase</li> <li>Non-refundable application fee in violation of state law</li> </ul>	<p>July 2005</p> <p>C &amp; D</p>
COMPANY NAME	INDIVIDUALS	CALIFORNIA: SUMMARY OF ALLEGATIONS	DATE/ACTION
A Capella Group, Inc d/b/a/ Care Entrée	*	<p><i>Texas-based company</i></p> <p>Acted as a health service plan without a license                      False advertising</p> <ul style="list-style-type: none"> <li>Claimed to provide discounts on medical services; in fact, discounts were available only if consumer established an escrow account containing enough funds to pay for medical services on or before the day they were rendered</li> <li>Claimed to provide unlimited access to provider network, but was only available if consumer established and maintained sufficient funds in an escrow account to pay for services</li> <li>Used misleading advertising, terms typically associated with insurance, e.g. "no pre-existing health care conditions"</li> </ul> <p>Claimed that there was a 30-day money back guarantee, but enrollment fee is non-refundable</p>	<p>July 2005</p> <p>C &amp; D</p>
Affordable Health Care Solutions, Inc / Continental Health Care	*	<p><i>No information given on company location</i></p> <p>Acted as a health service plan without a license                      False advertising</p> <ul style="list-style-type: none"> <li>Claimed to provide discounts on medical services, but had no contracts with providers to ensure that consumers were offered discounted prices</li> <li>Used terminology associated with the sale of insurance</li> <li>Engaged in deceptive price-advertising</li> </ul>	<p>December 2004</p> <p>C &amp; D</p>

		<ul style="list-style-type: none"> <li>Falsely claimed product was "risk-free" and used deceptive advertising techniques such as indefinitely extended limited-time offers</li> </ul>	
American ARC Management d/b/a Family Health	*	<p><i>No information given on company location</i></p> <p>Acted as a health service plan without a license</p> <p>False advertising</p> <ul style="list-style-type: none"> <li>Used terminology associated with the sale of insurance</li> <li>Offered product in conjunction with insurance products implying the sale of health insurance</li> <li>Engaged in deceptive price-advertising</li> </ul>	<p>December 2004</p> <p>C &amp; D</p>
Equal Access Health, Inc / Health Benefits of America	*	<p><i>Texas-based company</i></p> <p>Acted as a health service plan without a license</p> <p>False advertising</p> <ul style="list-style-type: none"> <li>Claimed plan provided discounts on medical services; in fact, discounts were available only if payment for services was made on or before the day services were rendered</li> <li>Discounts promised for providers that do not accept discount card</li> <li>Claimed that there was money-back guarantee, but plan only refunded full amount in limited cases</li> <li>Engaged in deceptive price-advertising</li> <li>Used terminology associated with the sale of insurance</li> </ul>	<p>July 2005</p> <p>C &amp; D</p>
Platinum Health Plus, LLC	*	<p><i>Florida-based company</i></p> <p>Acted as a health service plan without a license</p> <p>False advertising</p> <ul style="list-style-type: none"> <li>Claimed to provide discounts on medical services, but company had no arrangements with providers to offer discount prices</li> <li>Discounts were available only if payment for services was made on or before the day services were rendered</li> </ul>	<p>September 2004</p> <p>C &amp; D</p>
United Family Health Care Group	*	<p><i>No information given on company location</i></p> <p>Acted as a health service plan without a license</p> <p>False advertising</p> <ul style="list-style-type: none"> <li>Claimed plan provided discounts on medical services, but discounts were available only if payment for services was made on or before the day services were rendered</li> <li>Claimed to provide discounts on medical services, but providers did not accept card, and cash patients were able to obtain the same discounts without the card.</li> <li>Used terminology associated with the sale of insurance</li> <li>Failed to clearly disclose that discounts are only available if the consumer pays in full before or at time services were rendered</li> </ul>	<p>July 2005</p> <p>C &amp; D</p>

COMPANY NAME	INDIVIDUALS	FLORIDA: SUMMARY OF ALLEGATIONS	DATE/ACTION
American Dental Care, Inc	Michael Mazzini	<p><i>Texas-based company</i></p> <p>Sale of discount medical plans without license or certificate of authority Acted as insurer without legal authority</p>	<p>May 2006</p> <p>OIR Civil Action</p>
Memberworks, Inc.	Gary Johnson George Thomas	<p><i>Delaware-based company</i></p> <p>False and misleading advertising</p> <ul style="list-style-type: none"> <li>• Advertised “free gift” with trial membership; in fact, customers received vouchers and claim of “gift” required the consumer to pay numerous fees</li> <li>• Advertised a “risk-free” trial membership, failing to disclose fact that trial membership is automatically extended without cancellation</li> <li>• Utilized telemarketing scripts that intentionally deceive customers</li> </ul> <p>Failed to obtain consent before charging consumers’ credit cards Failed to change practices after receiving thousands of consumer complaints Failed to comply with contractual requirement and policy mandating the recording of consumers’ consent to sales</p> <ul style="list-style-type: none"> <li>• On tape recordings, marketers utilized ability to record specific sections of conversations in order to represent negative responses as successful transactions</li> <li>• Contracted with and accepted sales from marketers who did not have the ability to record conversations with consumers</li> </ul> <p>Participated in the practice known as “cramming,” which occurs when telemarketers process membership enrollment to consumers without making the required phone call</p> <ul style="list-style-type: none"> <li>• Florida consumer charged for the sale of two memberships; however, the consumer was deceased before the “sales” allegedly occurred</li> </ul> <p>Misrepresentation of provisions of membership limiting ability to receive discounts</p> <ul style="list-style-type: none"> <li>• Consumers led to believe that discount is received at the time of purchase, but it was actually presented later as a credit on a future credit card statement</li> <li>• Consumers were not notified of a limit on the number of times a discount may be used and a limit on the maximum dollar value of discounts allowed</li> <li>• Membership must be active to receive discount, often excluding customers who consent only to the “risk-free trial period” and cancel before the credit is awarded to their credit card</li> </ul> <p>Failed to disclose automatic renewal of memberships annually without cancellation Failed to state that membership materials must be returned in order to receive refunds Misrepresented the start date of the 30-day trial membership</p> <ul style="list-style-type: none"> <li>• Consumers led to believe that trial period begins once membership kit is received, but actual practice begins trial membership on the day information is provided regarding the membership plan</li> <li>• Consumers rarely have the promised 30 days to try programs before being charged, often receiving materials a few days before charged or after the charge occurs</li> </ul>	<p>October 2003</p> <p>AG Civil Action</p>

COMPANY NAME	INDIVIDUALS	ILLINOIS: SUMMARY OF ALLEGATIONS	DATE/ACTION
International Association of Businesses d/b/a IAB; International Association of Benefits d/b/a IAB; HealthCorp International, Inc d/b/a IAB	Robert W. Dailey Laura Gorman Jeffrey Malone Lois Nix Paula Rainey James C. Wood Roger Wood	<p><i>Texas-based company</i></p> <p>Acted as an unauthorized preferred provider administrator Engaged in deceptive and fraudulent practices</p> <ul style="list-style-type: none"> <li>• Consumers led to believe that they purchased health insurance when, in fact, they had purchased a health-related cash discount card</li> <li>• Used terminology associated with the sale of insurance</li> <li>• Required consumers to provide credit card number or checking account number to receive detailed information about the plan</li> <li>• Falsely displayed the Better Business Bureau OnLine Reliability program seal on web site when not authorized to participate in the program</li> <li>• Engaged in deceptive price-advertising</li> </ul> <p>Failed to provide promised refund when membership was cancelled within the advertised thirty-day refund period</p>	April 2005  AG Civil Action
COMPANY NAME	INDIVIDUALS	MINNESOTA: SUMMARY OF ALLEGATIONS	DATE/ACTION
Affordable Health Care/ Continental Health	*	<p><i>California-based company</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>• Utilized terms such as “health care” and “benefits” in a fax advertisement</li> <li>• Failed to explicitly state product was not insurance</li> </ul>	May 2005  C & D
All American Health Plan	*	<p><i>Texas-based company</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>• Utilized term “Health Plan” in a fax advertisement</li> <li>• Failed to explicitly state product was not insurance</li> </ul>	May 2005  C & D
American Medical Services	*	<p><i>Florida-based company</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>• Utilized term “health plan” in a fax advertisement</li> <li>• Failed to explicitly state product was not insurance</li> </ul>	May 2005  C & D
Colonial Health	*	<p><i>No information given on company location</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>• Utilized term “health care” in a fax advertisement</li> <li>• Failed to explicitly state product was not insurance</li> </ul>	May 2005  C & D
Equal Access Health	*	<p><i>Texas-based company</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>• Utilized term “health care” in a fax advertisement</li> </ul>	May 2005  C & D

		<ul style="list-style-type: none"> <li>Failed to explicitly state product was not insurance</li> </ul>	
Extra Health Family Plus	*	<p><i>No information given on company location</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>Utilized terms that would indicate sale of insurance</li> <li>Targeted Spanish-speaking audience</li> <li>Failed to explicitly state product was not insurance</li> </ul>	<p>May 2005</p> <p>C &amp; D</p>
Family Choice	*	<p><i>California-based company</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>Utilized term “health care” and “benefits” in a fax advertisement</li> <li>Failed to explicitly state product was not insurance</li> </ul>	<p>May 2005</p> <p>C &amp; D</p>
Med Health Plus/ Med Health One	*	<p><i>No information given on company location</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>Utilized term “health care” and “benefits” in a fax advertisement</li> <li>Failed to explicitly state product was not insurance</li> </ul>	<p>May 2005</p> <p>C &amp; D</p>
Peoples Health Plan/Health Care Advantage	*	<p><i>Florida-based company</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>Utilized terms relating to health insurance such as “monthly fee,” “one time enrollment fee” and “benefits” in a telephone conversation in attempt to solicit a customer</li> <li>Failed to explicitly state product was not insurance</li> </ul>	<p>May 2005</p> <p>C &amp; D</p>
Protective SmartHealth Plus	*	<p><i>No information given on company location</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>Utilized terms such as “insurance” and “benefits” in a fax advertisement</li> <li>Failed to explicitly state product was not insurance</li> </ul>	<p>May 2005</p> <p>C &amp; D</p>
Smart Health Care Solutions <sup>1</sup>	*	<p><i>Arizona-based company</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>Utilized terms such as “health care” and “benefits” in a fax advertisement</li> <li>Failed to explicitly state product was not insurance</li> </ul>	<p>May 2005</p> <p>C &amp; D</p>
US Healthcare/ Family Care	*	<p><i>Arizona-based company</i></p> <p>False and misleading advertisements</p> <ul style="list-style-type: none"> <li>Utilized terms such as “health care” and “benefits” in a fax advertisement</li> <li>Failed to explicitly state product was not insurance</li> </ul>	<p>May 2005</p> <p>C &amp; D</p>

COMPANY NAME	INDIVIDUALS	MONTANA: SUMMARY OF ALLEGATIONS	DATE/ACTION
All American Health Care Association; Continental Healthcare; Family Care; Family Health; Insure One; Med One; National Association of Preferred Providers (NAPP)	Wes Long Kristopher Aziz Rabie Michele Mahmoud Rabie Rhonda K Rabie Stephen Whatley	<p><i>All named companies have identical office locations in California, Florida, Texas and Wisconsin</i></p> <p>Acted as insurers without Certificate of Authority Advertised health insurance plan while actually providing access to a discounts through broker ppNEXT</p> <ul style="list-style-type: none"> <li>Failed to acknowledge fact that no participating providers existed in Montana</li> </ul>	June 2004  C & D
American Med Care; Continental Health; Health One; Liberty Discount Benefits; Med One; Medical Savings Program; Preferred Providers (NAPP)	Karen Leehin Penny Lee Wes Long Rhonda K Rabie Anthony J Pizzolo Bruce Weitzberg Steven Whatley	<p><i>All named companies have identical office locations in California, Florida, Texas and Wisconsin</i></p> <p>Acted as insurers without Certificate of Authority Designed deceptive ads</p> <ul style="list-style-type: none"> <li>False claims of “group health insurance”</li> <li>Failed to clearly state that the plan is not insurance</li> </ul> <p>Misrepresented facts</p> <ul style="list-style-type: none"> <li>Failed to acknowledge fact that no participating providers existed in Montana</li> </ul>	June 2004  C & D
Prudent Choice	Stephen T. Cook	<p><i>California-based company</i></p> <p>Deceptive marketing</p> <ul style="list-style-type: none"> <li>Indicated to consumer that company was “licensed with the State Insurance Board;” in fact, the company is not licensed by the state</li> </ul> <p>Sale of discount cards without certificate of certificate of registration Continued operations after the Department of Insurance advised operations to cease until authorized by the state</p>	March 2006  C & D
United Family Heathcare Group	*	<p><i>California-based company</i></p> <p>Acted as insurers without Certificate of Authority Designed deceptive ads</p> <ul style="list-style-type: none"> <li>False claims of “employee group health care”</li> </ul> <p>Misrepresented facts</p> <ul style="list-style-type: none"> <li>Claimed over 270 Montana medical providers accepted plan, while investigation found that no participating doctors in Montana</li> </ul>	June 2004  C & D
Ameriplan USA Corporation	Daniel Bloom Dennis Bloom Shirl Shelley	<p><i>Texas Based Company</i></p> <p>Operated in state without registering as a medical care discount card provider False advertising</p>	July 2006  C & D

		<ul style="list-style-type: none"> <li>Claimed to have contracted with hundreds of medical care providers, 30,000 dentists and 7500 chiropractors, when few, if any named providers had contracts with the plan</li> </ul>	
COMPANY NAME	INDIVIDUALS	NEW YORK: SUMMARY OF ALLEGATIONS	DATE/ACTION
MedAdvantage, LLC	Alene Ketchledge Claude Oster	<p><i>Michigan-based Company</i></p> <p>False and misleading advertising</p> <ul style="list-style-type: none"> <li>Claimed savings “up to 40%” on prescription drugs, but the majority of claims (67%) were discounted at only 29% or less</li> <li>Claimed savings “up to 50%” on eye care, but the majority of claims (53%) were discounted at only 39% or less</li> <li>Claimed access to over 20,000 dentists, but actual numbers varied</li> </ul> <p>Failed to disclose important information, including:</p> <ul style="list-style-type: none"> <li>Additional fees (administrative, dispensing and banking fees) in advertisements</li> <li>Member must have enough credit on credit or debit card to cover the providers’ customary fee at the time of service to be eligible for discount</li> <li>No disclosure that the product was not insurance</li> <li>Some eye exams subject to a pre-arranged flat fee and not subject to additional discounts</li> </ul>	2003  Assurance of Discontinuance
Medisavers, Inc	Alvin Konigsberg David Konigsberg	<p><i>New York-based company</i></p> <p>False advertising</p> <ul style="list-style-type: none"> <li>Claimed to have provided health care services for “over 40 years,” but company only existed since March, 1996</li> <li>Claimed to provide savings “up to 80% on <u>all</u> health care costs” (Only 20% of dental claims were discounted at 80% or above and including administration fees, no savings above 65% were received; only 15% of primary health care claims were discounted at 80% or above, and including administration fees, no savings above 73% were received)</li> <li>Claimed participation of “over 250,000 nationwide health care providers, 2,500 hospitals and all major chain drug stores and neighborhood pharmacies” as participating providers on company’s website and found that: 1) Company could only produce names of 222,055 providers that currently participate; 2) Investigators contacted 25 of the doctors listed and found that none of the providers recognized the company’s name and only three were aware of participation in the network to which members belonged; 3) Only hospitals in New York, New Jersey and Florida currently participate; 4) Several major chain pharmacies denied involvement in program</li> </ul> <p>Failed to disclose important information, including:</p> <ul style="list-style-type: none"> <li>Company charged an administration fee</li> <li>Member must have enough credit on credit or debit card to cover the providers’ customary fee at the time of service to be eligible for discount</li> <li>Process through which members were to obtain promised discounts</li> </ul>	July 2002  Assurance of Discontinuance
National Association	Roger Blackman	<i>Texas-based company</i>	March 2004

of Preferred Providers/Family Care	Mario Bunster Jaren Current Michael Rabie	<p>False advertising</p> <ul style="list-style-type: none"> <li>• Claimed savings up to 80% on medical services, but three quarters (over 77%) of claims received discounts below 50%</li> <li>• Claimed savings of 80% on dental care, 60% on vision care and 60% on hearing care and products without substantial evidence</li> <li>• Claimed that company offered a "Health Plan," implying that the product offered was insurance</li> <li>• Claimed program was affiliated with "a National Health Benefits Association," but no such entity exists</li> <li>• Claimed to provide "preferred prices," but later states that it "...does not guarantee...the lowest cost to its members..."</li> </ul> <p>Failed to disclose important information, including:</p> <ul style="list-style-type: none"> <li>• Company charged an enrollment fee</li> <li>• Program was not insurance</li> <li>• Process through which members were to obtain promised discounts</li> </ul>	Assurance of Discontinuance
Chamber of Commerce Association, Inc/Greater New York Chamber of Commerce; US Capital Healthcard Bft Inc/Chamber Health/US Healthcard;	Samuel J Eisenberg Mendy Farro Meyer Gutnick	<p><i>New York-based company</i></p> <p>False advertising</p> <ul style="list-style-type: none"> <li>• Claimed savings "up to 90%;" but savings were typically far below 90%</li> <li>• Claimed participation of 50% of all U.S. doctors</li> <li>• Implied that immediate enrollment reduces monthly rates, when consumers actually get a standard, pre-determined rate regardless of time of enrollment</li> <li>• Falsely claimed that company was the only program geared toward the uninsured</li> <li>• Claimed to be endorsed by the "National Health Alliance," but entity is fictitious and does not exist</li> <li>• Advertised on the Chamber of Commerce Association's website under link for "Health Insurance"</li> </ul> <p>Failed to disclose important information, including:</p> <ul style="list-style-type: none"> <li>• Deposit was necessary to receive benefits for services received in hospitals</li> <li>• Payment for hospital bills is due within 30 days of discharge</li> </ul>	June 2002  Assurance of Discontinuance
<b>COMPANY NAME</b>	<b>INDIVIDUALS</b>	<b>TEXAS: SUMMARY OF ALLEGATIONS</b>	<b>DATE/ACTION</b>
International Association of Benefits (IAB)	George Katosic	<p><i>Texas-based company</i></p> <p>Engaged in false, misleading and deceptive acts</p> <ul style="list-style-type: none"> <li>• Led customers to believe that they were purchasing insurance products</li> <li>• Explicitly stated that the "health care plan" offered is not a health discount plan and indicated that benefits provided were similar to those expected of insurance; Indicated that plan included \$35 doctor's visits at eight out of every ten doctors, payment of up to 80% of any additional health care costs, and payment up to \$5,000 for accidents and emergency room visits</li> </ul>	2005  AG Civil Lawsuit

		<ul style="list-style-type: none"> <li>Indicated to consumers currently enrolled in an insurance policy that company's product offered superior benefits at a smaller cost, causing many to terminate their old insurance plans</li> <li>At time of purchase, company informed customers that full refunds could be obtained if cancellation of membership was received within the first 30 days, but when customers attempted to cancel, insisted that the refund period is only the first seventy-two hours after signing up</li> </ul> <p>Sent facsimile solicitations without correct and complete name of the person making the facsimile solicitation and the street address of the location of the person's place of business, in violation of state law</p>	
American Senior Alliance, Inc.	George Katosic	<p><i>Texas based Company</i></p> <p>Misrepresenting company as a non-profit seniors advocacy group Using misleading name and marketing methods to collect personal information for sales leads for his client companies Failed to disclose name of insurer or agent he was collecting information for</p>	<p>2006</p> <p>AG Civil Lawsuit</p>
The Capella Group, Inc. d/b/a Care Entrée; Equal Access Health, Inc. d/b/a Health Benefits of America, E. A. H., EA Health, Equal Health, Equal Health.com H.B.A. and Associates, Health Care for the Entire Family	*	<p><i>Texas-based company</i></p> <p>Engaged in false, misleading and deceptive acts</p> <ul style="list-style-type: none"> <li>Indicated that product could be used as a cost-effective replacement to health insurance but failed to mention that product was not insurance</li> <li>Failed to disclose important facts until after membership was purchased and materials were received including: health care program is not insurance; consumer is responsible for the total cost of services in full at the time services were rendered; enrollment fee is non-refundable; participating providers were subject to change at any time without notice; cancellation of the plan had to be received in writing; enrollees must wait 30 days before receiving savings on hospitalization; deposit is required for hospitalization; no additional discounts for services that are billed at the Medicare discounted rate</li> <li>Misrepresented expected discounts</li> <li>Indicated a "satisfaction guarantee" but thwarted unsatisfied customers' efforts to cancel plan</li> <li>Calls to customer service telephone lines reached only a voicemail box</li> <li>Continued to withdraw funds after customer had cancelled membership in writing or spoken to a representative on the phone</li> </ul>	<p>2005</p> <p>AG Civil Lawsuit</p>
<b>COMPANY NAME</b>	<b>INDIVIDUALS</b>	<b>FTC: SUMMARY OF ALLEGATIONS</b>	<b>DATE/ACTION</b>
Platinum Health Plus, LLC	Alexander R. Garcia Michael P. Garcia	<p><i>California-based company</i></p> <p>Misrepresentations and omissions of material fact</p> <ul style="list-style-type: none"> <li>Used terminology that would indicate that the product was insurance</li> <li>Included product with other insurance policies</li> <li>Disclaimers did not prevent consumers from belief that the product is insurance</li> </ul>	<p>September 2005</p> <p>FTC Civil Lawsuit</p>

		<ul style="list-style-type: none"> <li>Falsely indicated a 30-day money back guarantee; in television advertisements, claimed “exclusive guarantee” and “risk-free” memberships without disclosing the fact that refunds were provided only if the program had been used within the first 30 days; Until September of 2004, the refund policy was not mentioned at all during telephone sales presentation, and afterwards, was hastily mentioned during a lengthy presentation after the customer provided credit or checking account information</li> </ul>	
Remote Response Corporation also d/b/a Amerikash, Global-Amerikash, AmerikHealth and Instant Way	Alberto Salama German Espita	<p><i>Florida-based companies</i></p> <p>Engaged in unfair practices while selling a credit card and offering several free gifts with purchase, including a “15-day free trial membership” to a discount health plan, which had to be cancelled within 15 days in order to avoid automatic withdrawal of funds</p> <ul style="list-style-type: none"> <li>Charged consumers for plan even if the consumers declined the free trial offer</li> <li>Charged consumers for plan even if consumers did not receive the discount health plan materials with sufficient time to utilize the materials within the 15-day trial period</li> <li>Charged consumers multiple times in one month for a “monthly fee”</li> <li>Actively thwarted consumers’ attempts to cancel plan by referring them to message machines, failing to return calls, and terminating the phone calls</li> </ul>	February 2006  FTC Civil Lawsuit

“C & D” stands for Cease and Desist Order