



# Issue Brief

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## Discount Medical Cards: Innovation or Illusion?

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**ABSTRACT:** Discount medical cards have come under increasing scrutiny by regulators and law enforcement officials as a result of mounting consumer-reported problems. For their study, the authors tested five cards available in the Washington, D.C., metro area; interviewed card company representatives, state attorneys general, insurance regulators, and insurance agents; and reviewed court and administrative actions. While some cards provide a measure of value, other cards were found to have serious drawbacks, including: high-pressure sales tactics; misleading or inaccurate promotion; exaggerated claims of savings; difficulty finding participating doctors; and providers who failed to give cardholders promised discounts. Some discount card companies are seeking to reform the market through a trade association and voluntary code of conduct. Still, legislative and regulatory interventions will be needed to protect consumers in an unregulated and growing market.

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### Background

Double-digit premium increases over the past four years have made health insurance unaffordable for many Americans. As an alternative to insurance coverage, some consumers are turning to discount medical cards, which can allow the purchaser to obtain services at reduced fees from participating doctors, hospitals, and other providers. But as reports of a variety of consumer problems—from exaggerated discounts to nonexistent provider networks—mount, these cards have come under growing scrutiny from regulators and law enforcement officials.

To understand the challenges facing consumers, the authors tested five of the 27 cards advertised in the Washington, D.C., metro area by undergoing the application process, seeking health care services from participating providers, and then canceling the cards. (Only nine of the 27 products identified were eligible for study; the other 18 cards could not be studied because of nonworking telephone numbers, lack of provider discounts, or other reasons.) In addition, the researchers interviewed representatives from companies

offering discount cards, state attorneys general, insurance regulators, and insurance agents. They also reviewed court and administrative actions.

While there are examples of cards providing value, other cards had serious drawbacks, including: high-pressure sales tactics; misleading or inaccurate promotion; exaggerated claims of savings; difficulty finding participating doctors; and providers who failed to give cardholders promised discounts.

Some discount card companies are seeking ways to make the market more reputable by forming a trade association and instituting a voluntary code of conduct. But with few consumer protections currently in place, legislative and regulatory interventions are needed to protect consumers in an unregulated and growing market.

#### **DISCOUNT MEDICAL CARDS: PROBLEMS FOR CONSUMERS**

<i>Marketing/sales</i>	<ul style="list-style-type: none"> <li>• Misleading advertisements</li> <li>• Disconnected telephone numbers</li> </ul>
<i>Purchasing cards</i>	<ul style="list-style-type: none"> <li>• Misleading information and claims that a discount card is insurance</li> <li>• High-pressure sales tactics</li> <li>• High enrollment fees and high monthly fees</li> </ul>
<i>Using cards</i>	<ul style="list-style-type: none"> <li>• Providers listed in directories not participating</li> <li>• Discounts less than promised</li> <li>• Discounts for uninsured or cash-paying patients greater than for cardholders</li> </ul>
<i>Canceling cards</i>	<ul style="list-style-type: none"> <li>• Inaccurate information on how to cancel</li> <li>• Refund less than promised</li> </ul>

#### **WHAT ARE DISCOUNT MEDICAL CARDS?**

Unlike dental and vision cards, which have been in existence over a decade, discount medical cards are relatively new products.<sup>1</sup> These cards—also called

discount health plans, discount medical plans, and discount health cards—promise discounts for a broad range of providers, including doctors and hospitals, as well as for laboratory work, surgical procedures, and other services. In return for the negotiated discount, members must pay a monthly fee ranging from about \$13 per month to \$148 per month for a single person; usually, there is also a nonrefundable, one-time enrollment fee, which can be as high as \$200.

Unlike health insurance policies, companies offering discount cards do not pay medical claims of the individuals enrolled. Instead, they negotiate discounts with provider networks or, in some cases, with providers directly.<sup>2</sup> Enrollees are responsible for paying the amount of their claims. To receive a discounted rate, enrollees must pay for services in full at the time of service or prior to receiving care. Some discount medical cards are linked to payment mechanisms. For instance, one company requires enrollees to prepay for services through an escrow account.<sup>3</sup> Another offers a credit card with the discount card to allow enrollees to charge services they cannot pay for fully at the time of service.<sup>4</sup>

#### **A GROWING MARKET**

Discount medical cards are growing in prevalence, partly because of the high prices of and limited access to private health insurance coverage. In fact, some small businesses and individuals have enrolled in discount medical cards after dropping their health insurance following price hikes.<sup>5</sup> Discount cards are also attractive to people with preexisting conditions, who cannot obtain individual insurance or are only eligible for very high-priced policies.<sup>6</sup> Cardholders do not have to pass medical underwriting, pay the same cost regardless of health or age, and cannot be excluded because of a preexisting condition.

Unfortunately, some consumers may mistakenly buy discount cards based on the erroneous belief that the cards are insurance policies.<sup>7</sup>

Marketers use insurance terminology like “no underwriting” and “no preexisting conditions,” leading people to presume incorrectly that they are buying insurance. Also, the monthly fee—which can be as high as the monthly cost for catastrophic insurance—can mislead people into thinking that it is actually an insurance premium. Some discount medical cards, moreover, are sold with accident insurance coverage that pays medical bills resulting from an accident; others are sold with hospital indemnity insurance policies that pay for hospital stays.<sup>8</sup> This bundling of noninsurance and insurance products may cause further confusion.

### **HOW MANY PEOPLE HAVE A DISCOUNT MEDICAL CARD?**

There are no data on how many people have a discount medical card, nor are there demographic data on those enrolled. One large discount card company reports that nearly 680,000 people have enrolled in its physician discount program.<sup>9</sup> Another company reported more than 81,000 enrollees and \$39.3 million in revenue in 2003.<sup>10</sup>

### **MARKETING OF CARDS**

Companies that administer and manage discount cards sell their product in three ways: directly to consumers; through other companies, like associations; or by independent sales agents (including insurance agents) and marketing firms.<sup>11</sup> One publicly traded company reports that it devotes 37 percent of its operating expenses to sales and marketing, including recruitment and training of an independent sales force and sales commissions.<sup>12</sup> This company uses a technique known as “network marketing,” under which marketers recruit other marketers and receive commissions based on their sales.<sup>13</sup>

Unlike insurance agents, promoters of discount cards are generally not regulated or licensed, meaning that there are few standards that apply to sales or sales methods. In preparing this issue brief, the authors reviewed marketing materials that used scare tactics, misleading information, and exaggera-

tion to attract buyers. The following is an unedited excerpt from a telemarketing script used to sell one national card:

At this moment in time you have no insurance coverage. What if something were to happen to you or anyone in your family like an accident that required immediate attention. What if the closest hospital is a private hospital, as you know, the first thing that the hospital will ask [sic] you for is your insurance card. And if you don't have any they won't admit you. They'll just tell you to go to the county hospital. Now there have been nightmares and horror stories about people dieing [sic] on their way to the county hospital because they didn't have insurance. Everyday that you wait is another day that you don't have that Emergency Protection. No one likes to think like this but, What if you're one day too late. By enrolling Today you'll Never have to say WHAT IF again!!<sup>14</sup>

Promoters solicit business in a variety of ways, including advertising on television, radio, and the Internet, as well as through fax, e-mail, and telemarketing.<sup>15</sup> Some consumer groups, associations, retailers, and credit card companies have endorsed or affiliated themselves with discount card programs.<sup>16</sup> According to an August 2004 article in the *Chicago Tribune*, a pastor in Illinois sold discount medical cards to his parishioners.<sup>17</sup>

### **FIELD TEST OF DISCOUNT MEDICAL CARDS**

To test how well discount medical cards work, the authors in August, September, and October 2004 enrolled in, used, and disenrolled from five cards that offered discounts for health care services in the greater Washington, D.C., area. (See page 12 for complete [study methodology](#).)

### **Enrollment Process**

The authors found considerable variation in enrollment experiences. Promoters of two of the five cards gave detailed explanations of how the cards work, how they differ from insurance, and how they can be used in combination with insurance in

certain circumstances. These promoters did not pressure the researchers to enroll.

With three of the cards, however, the authors experienced high-pressure sales tactics, misleading and inaccurate benefit information, and, in one case, a significant delay in receiving the discount card and membership packet. The promoters of these cards pressured the authors to enroll by telling them that the open-enrollment period was about to end and that the opportunity to enroll, regardless of health status, would end when open enrollment closed. They also said that the price would increase unless the authors enrolled immediately, or that the offer would expire on the date of the call or within the week.<sup>18</sup>

These promoters also made misleading statements about the cards. For example, one promoter did not disclose that the discount card was not insurance. When asked to clarify hospital discount benefits, another promoter—who offered accident coverage as a part of the discount card package—confused the discount and the accident coverage by stating that the authors would be covered for \$10,000 of hospital care. This promoter did not say the insurance coverage was only for accidents. Moreover, several promoters emphasized that all preexisting conditions were “covered,” there were no age limitations, and no one would be turned down because of a health condition. By using insurance terms and improperly explaining benefits, some consumers could mistakenly believe they are buying health insurance.

Three cards had an external verification process under which the authors had to verify to a third-party computer system that they had received certain disclosures—for example, that the card is not an insurance plan, and they consented to enrollment. However, some promoters had developed ways to get around the process. One promoter answered questions on behalf of the author—without actually asking her. The author was responsible only for stating her name and date of birth. During this process, the author was

unable to hear most of the information being verified. When the author complained about this, the promoter instructed her to hold her questions and press a number on the keypad, indicating acceptance of the terms of agreement. The author could not hear much of the subsequent recorded agreement, but did hear information that contradicted what the promoter promised about the refundability and amount of the enrollment fee.

In some cases, the authors were told to accept the terms of the agreement without actually seeing it. One card company promised a follow-up call to verify certain information, but never provided the follow-up.

Another enrollment problem encountered was the length of time it took to receive the discount card and information packet. In one case, more than three weeks passed before the author received these materials, making it impossible to use the benefits for which the author has already paid. The authors did receive information for four of the five cards within one week of enrollment. (See [Appendix A](#) for more information about the enrollment process.)

### **Using Discount Cards**

Once enrolled, the authors tested the cards to see how well they worked. The most significant challenge was finding health care providers who accepted the cards. Three cards did not provide a list of providers prior to enrollment. Following enrollment, each of these three card companies gave the authors inaccurate information about providers. As a result, the authors had to contact these companies repeatedly to find participating providers who would accept the card. In many instances, the customer service agents supplied incorrect phone numbers (including a number for an auto garage). Even when the information provided was accurate, the authors had to contact the companies repeatedly because providers either did not accept the card or did not give discounts to cardholders.

In total, the researchers contacted 44 medical providers. Of these, 16 honored the card, but only nine provided an estimated discount. In one case, the researchers contacted 12 providers whose information was provided by the card company and found that only one recognized and accepted the card.<sup>19</sup> Of the five cards tested, only one had a 100 percent record of providers offering discounts to cardholders (Table 1).<sup>20</sup>

within 15 percent of the upper limit promised. Discounts for the other two cards either were substantially less than promised or the authors were not able to obtain estimates from the providers. Two of the five cards promised an 80 percent discount, but the authors were unable to find a provider who offered such a discount.

In several cases, discounts were also available to non-cardholding patients paying cash. One

**Table 1. Reaching Providers**

Card	Number of Providers Able to Contact*	Number of Providers Accepting Card	Promised Savings	Actual Discount	Discount for Cash-Paying or Uninsured Patient
1	9 of 12	1	15%–40%	30%	None
2	6 of 9	4	15%–40%	20%–25%	2 of 4 providers; amount varied, depending on individual's circumstance
3	7 of 7	7**	Up to 40%	4%–34%	None
4	5 of 9	3	50%–80%	6%–36%	2 of 3 providers; amount varied for one provider, depending on individual's circumstance; the other provider gave 30% off (6% off to discount cardholders)
5	4 of 7	1	25%–80%	Estimate not provided	None

\* We were not able to contact providers for one of two reasons: 1) the phone number was disconnected; or 2) discount card company gave us incorrect contact information for the provider.

\*\* One provider offered a discount for the first visit only.

Source: Authors' review and analysis of a selected group of discount medical cards, 2004.

To determine how the discounts compared to noncardholder rates, the authors asked the providers for their regular price, the rate for an uninsured individual paying cash, and the rate for cardholders. Prices were compared for the following medical events: standard annual physical from a physician; standard annual gynecological visit (with Pap test; lab fees not included); and an initial visit to an allergist that included testing for allergies (skin test/scratch test).

The level of discount varied from between 4 percent and 36 percent off the providers' regular rates. For two cards, the discount quoted was consistent with what was promised in advertisements and in the enrollment materials—within 10 percent of the upper limit promised. One card was

provider gave uninsured patients a discount of \$45 off the usual and customary fee of \$155; the discount for a cardholder would be only \$10.<sup>21</sup>

Even when providers offered discounts, only the two least expensive cards provided any measure of value when the authors figured in the cost of the monthly fee and enrollment fee. The two least expensive cards did provide some level of savings. For example, one card (monthly fee of \$12.99 and no enrollment fee) provided savings of \$80 on an annual gynecological exam and \$25 on a routine physical with a physician. Because the first 60 days for this card cost only \$1, the net savings equaled \$104. However, one drawback is that although all providers contacted said that they participated, not all were able to say what the amount of the

discount would be—making it difficult for consumers to plan.

With the second, more expensive card (monthly fee of \$24.95 and \$10 enrollment fee), the authors saved \$30 on a routine physical and \$94 on an annual gynecological exam. The net savings were approximately \$89.

Only one of these cards delivered on the promised savings with each of the providers we contacted. The second card did not have a 100 percent provider acceptance rate. Moreover, the monthly cost of a card is not correlated with the level of discount provided; that is, higher-priced cards do not necessarily offer a greater discount.

### Cancellation

Consumers must be able to cancel discount medical cards on demand. The authors' cancellation experiences were mixed. They were able to cancel four of the five cards without incident, although one card reimbursed less than the amount promised (Table 2). Two cards permitted cancellation over the phone, while the others required written cancellation (one card accepted this correspondence via e-mail).

The other card, however, was difficult to cancel. This company tried to persuade the researchers to stay enrolled by offering a free month. It also gave inaccurate information about cancellation procedures and failed to refund the monthly fee in full, even though there was a 30-day, money-back cancellation policy. The cancellation process, contrary to information included in the enrollment package, was complex. The company required a certified letter sent to one location to notify the company of intent to cancel membership and another letter to a different address in order to receive a refund of the first month's fees.

### DISCUSSION

Consumers who enroll in discount medical cards may receive inaccurate information during the enrollment process, have trouble getting the care they need at the promised discounts, and may incur unexpected costs when disenrolling because they do not receive promised refunds. Only one of the five cards tested appeared to offer a net value, meaning the discount on doctors' services was greater than the cost of the card and the card had

**Table 2. Getting a Refund After Cancellation**

Card	Refund Policy	Amount Paid	Amount Promised to Refund	Amount Refunded
1	Refundable, but inconsistent information about the amount of refund	\$179.95 (monthly fee \$89.95 and enrollment fee \$90)	\$179.95	\$140 (Less than promised refund)
2	Refundable*	\$34.95 (monthly fee \$24.95 and enrollment fee \$10)	0	0
3	Refundable	\$1 (introductory rate for 60 days)	\$1	\$1
4	Enrollment fee not refundable Unclear if monthly fee is refundable	\$94.95 (monthly fee \$44.95 and enrollment fee \$50)	0	0
5	Refundable*	\$170 (monthly fee \$50 and enrollment fee \$120)	0	0

\* Monthly fee refundable only if cancelled within 30 days. Card number 2 was not canceled within 30 days. Card number 5 could not be canceled within 30 days because enrollment and benefits information did not arrive for over three weeks.

a 100 percent rate of provider acceptance. Although one other card produced savings, only four of the nine providers accepted the card.

If the authors had kept the one card that did offer value for six months (at a total cost of \$52.96), and they had one visit to a gynecologist for an annual exam, the net savings would have equaled \$27.04 (\$80 provider discount minus \$52.96 card cost for six months). If the authors also received an annual physical from a physician and visited an allergist (with allergy testing), the savings would have been even greater. Four of the five discount medical cards tested, on the other hand, offered little value: high costs and small discounts, coupled with the significant amount of time and labor needed to find participating providers, detracted from the potential value.<sup>22</sup>

### Regulatory Issues

Discount medical cards are not insurance policies and are therefore not regulated like insurance products. Due to jurisdictional constraints and a lack of specific laws, states have had limited success in protecting consumers.

**Types of regulations.** Discount medical cards and the companies that operate them are generally subject only to fraud and deceptive marketing prohibitions enforced by state attorneys general after consumers report problems. Federal and state health insurance standards—including regulation of rates, requirements to have adequate provider networks, advertising standards, and financial integrity—do not apply. This regulatory vacuum, coupled with consumers' expectations, has created opportunities for fraudulent behavior and practices that would be prohibited in the insurance industry.<sup>23</sup>

Unlike insurance departments that can help prevent problems from occurring, state attorneys general (AGs) only deal with problems after the fact. To combat deceptive and unfair trade practices, an AG must bring a lawsuit, but only after receiving a pattern of complaints. Lack of state

laws specifically regulating these cards makes it difficult to address problems even after they occur.

**Consumer concerns.** Consumers have reported a range of problems to state attorneys general and state insurance regulators. Florida's insurance regulators reported nearly 800 consumer inquiries and complaints during a nine-month period (June 3, 2003, to March 1, 2004).<sup>24</sup> Reported problems included consumers who believed they bought insurance, consumers who paid for cards but never received the membership package, providers who did not accept the cards, and consumers who did not receive information about who to contact with problems.<sup>25</sup> According to Maryland's insurance department, most discount card complaints are brought by consumers who thought they purchased insurance.<sup>26</sup>

In New York, one discount card program claimed "savings as high as 90 percent off the usual and customary fee" in its advertisements. The New York State AG's office found that the claimed discount was greatly exaggerated and that typical savings were closer to 15 percent off the usual rate.<sup>27</sup>

Other problems included an endorsement by a nonexistent entity, false claims about the number of providers participating, and a failure to disclose important benefit information, including a required prepayment of \$1,000 for each projected day in a hospital and a requirement to make payment in full within 30 days of a hospital stay. According to the investigators, the hospitalization benefit was illusory. In another case, the AG's office found that enrollees were required to have a working credit card. If cardmembers could not pay fully at the time of the service, their credit cards would be billed at a non-discounted rate. The AG also found one case in which consumers paid drastically different rates for the same program—from \$54.95 per month to \$120 per month.<sup>28</sup>

In addition, there have been reports of outright fraud, either selling cards without a provider network—Montana has shut down 11 companies that sold cards without a network—or marketing

scams purporting to sell discount card programs. Telemarketers purporting to sell discount medical cards get personal information from unsuspecting consumers and then inappropriately bill credit cards or make bank account withdrawals. Consequently, the Federal Trade Commission issued a consumer alert warning people against buying a discount card through a telemarketer.<sup>29</sup> Additionally, there have been cases where a company selling discount cards has billed an individual's credit cards or made withdrawals from his or her bank account *after* the individual had cancelled the discount card.<sup>30</sup>

**State responses.** Due to a lack of clear standards and regulatory authority, many AGs and insurance commissioners have focused on issuing consumer alerts and educational pamphlets instead of taking steps to change the business practices of these companies. There are, however, a few notable exceptions.

Several AGs' offices have pursued actions against discount cards using their authority under Deceptive and Unfair Trade Practices Acts. New York's AG has been very active in this regard, investigating and bringing actions against discount card companies for false and misleading practices, as well as issuing guidelines to assist the industry in creating advertising and marketing materials that are lawful and nondeceptive.<sup>31</sup> There is no penalty, however, for companies that violate such guidelines. AGs in Kansas and Florida have also filed lawsuits.<sup>32</sup>

Some states are attempting to regulate the market. To date, 13 states require companies to disclose that a discount medical card is not insurance.<sup>33</sup> Additionally, a handful of states have specific standards for advertisement and marketing. In eight states, discount medical card programs are required to contract separately with providers to address concerns that providers are not aware of their participation in the programs. However, in some cases the standards are not clear as to whether a contract between a PPO and a provider is sufficient to meet

the requirement for having a contract between the provider and a discount card company.<sup>34</sup>

State insurance regulators and assistant AGs have also identified the problem of discount card companies not providing information regarding companies' locations, making it difficult to file a civil action. Some states have begun to require companies to disclose their location.<sup>35</sup>

Actions by state insurance regulators have been limited, although a few states have used their authority to shut down unauthorized insurers in order to close down discount medical card companies. For instance, Montana's insurance commissioner shut down 11 discount card companies operating in the state that falsely claimed to have discounts with provider networks.<sup>36</sup> In addition, Oklahoma's insurance department has shut down several discount card companies.<sup>37</sup> Insurance regulators in these and several other states are seeking legislative changes and expanded regulatory authority over discount cards.

A more aggressive approach to protecting consumers is just starting to emerge: licensing. In 2004, Florida passed a law requiring companies to be licensed to operate a discount card program. Such companies would need a minimum net worth of at least \$150,000 and be subject to a background check for its operators (e.g., for felony convictions). Additional requirements would include supplying an up-to-date list of the names and addresses of contracted providers, having their rate approved by the insurance department when the monthly fee is more than \$30, meeting advertising standards, and filing an annual report with the Office of Insurance Regulation.<sup>38</sup>

In addition to these individual steps taken by state attorneys general and insurance regulators, the National Association of Attorneys General and the National Association of Insurance Commissioners (NAIC) each have established working groups to study discount cards. The NAIC held a public hearing in December 2004 to find ways to better address reported consumer problems.<sup>39</sup>



**Industry responses.** Several discount card companies have formed a trade association called Consumer Health Alliance (CHA). Although, as in other industries, the member companies are concerned about over-regulation, the companies interviewed for this report are unanimous in their belief that misleading marketing, as well as outright fraud, gives the entire industry a bad reputation. According to one card company's CEO, CHA's goal is to "eliminate bad actors." Referring to companies that do not have contracts with providers or networks, another CHA member said there are "lots of bad players right now . . . total scams," but also said that "this is a wonderful product and should be sold for what it is, not for what it's not."<sup>40</sup>

In response to some of the reported problems, CHA's members have developed a voluntary code of conduct. Under these standards, member companies must provide a toll-free number for enrollees to access information regarding providers, rates, and discounts; have a statement disclosing that the discount program is not insurance; have a policy that allows cancellation within 30 days for a full refund of all membership fees, excluding enrollment fee; and provide information about a company's complaint process. The code also requires companies to have contracts, with information included on the discount program (e.g., the amount of the discount or fee schedule) with participating providers or networks.<sup>41</sup>

In addition, several CHA members have adopted business practices that seek to address problems of misrepresentation. For example, several member companies employ a verification process to ensure consumers understand the card is not an insurance product and have realistic expectations of discounts. To help prevent issues of false claims and marketers who circumvent the verification process, one CHA member company has discontinued the use of network marketing to sell its products.

One major problem that consumers, as well as the researchers of this project, have encountered is that the providers supplied by the card compa-

nies do not accept the discount card. Partly this can be attributed to PPOs who have contracted with the card companies, as these companies do not always notify providers about the program. One CHA member company requires its contracted PPO to notify participating providers about the discount card program. Providers who do not wish to offer discounts may then contact the company to be removed from the list of participating providers.

In response to unauthorized charges or bank account withdrawals, one company has kept billing and payment in-house to help prevent unauthorized charges by others selling its program. To avoid unreasonable monthly charges, this company, a discount wholesaler, maintains control over price when the program is resold.<sup>42</sup>

## CONCLUSION

With few affordable health insurance options, interest in discount medical cards will likely increase. While there is insufficient information available to determine if discount medical cards are meeting consumers' needs, the authors' experience with some discount cards raises serious concerns. Issues included questionable and perhaps unlawful marketing practices, a lack of available providers, discount rates that were not as high as promised (and that could possibly be achieved by non-cardholders who negotiate directly with providers), and disenrollment processes that are often complicated and costly because promised refunds did not materialize. The authors' experience is consistent with the types of problems reported to and investigated by state AGs and insurance commissioners.

Legislative action is needed that gives state insurance departments the authority and resources to have direct oversight of the discount medical card industry. Creating regulations, like those that govern insurers and their products, as well as specific standards applicable to discount medical cards, would help prevent many consumer problems. Specific standards for discount medical cards would

also help state AGs to better protect consumers after problems occur. Actions that could help protect consumers include the following:

- Require companies to be licensed with the insurance department, to post a bond in case of problems, and to undergo a background check. Many states have been unable to track down the source companies and fine them for deceptive and fraudulent behavior. Licensing requirements would require companies to disclose information, making it easier for states to enforce their laws.
- Require companies to have contracts directly with providers, not just with their PPO networks.
- If companies allow their programs to be resold or marketed by promoters, then they must maintain control over advertising and be held accountable for misleading, deceptive, or fraudulent information offered by promoters or agents.
- Discount medical card programs should be required to provide clear, comprehensible consumer disclosures prior to enrollment, as well as in the enrollment documents. For example, regulators should require companies to clearly state: a) that discount cards are not insurance; b) that consumers are responsible for the entire bill, either at the time of service or prepaid; and c) that if the bill is not paid in full at the time of service, then the discount is not available. The companies should also explain that, unlike health insurance, the discount card does not count toward reducing a preexisting condition when an individual buys health insurance. Once the individual has a medical condition or needs medical care, consumers may not be able to buy health insurance. The disclosure should include an accurate description of benefits, such as the amount of the median discount instead of the highest level, and the names of participating providers in various zip code areas.
- Similar to insurance products, consumers should have an opportunity to have a “free look” period. If a consumer cancels, then both the enrollment fee and the monthly fee ought to be refunded. Cards should have clear refund policies.
- Just as insurer’s rates must be reasonable in relation to the benefits provided, discount cards should also maintain standards for rates.
- States should consider a suitability standard. Under such a requirement, an agent would have to inform a low-income person that free or reduced medical care may already be available through community health centers or other programs. Discount medical cards should not be sold to people who qualify for public health insurance programs because, at best, the card would duplicate discounts already available. For low-income people who cannot afford to pay for a provider visit at the time of service, savings with a discount card are illusory.

These types of legislative and regulatory interventions are necessary to better protect consumers. Even with new laws, some companies will choose not to be licensed. It is important that resources be available for state agencies to find such companies and hold them accountable. Unlike comprehensive health insurance, discount medical cards alone do not provide financial security or access to needed medical care.<sup>43</sup>

## NOTES

<sup>1</sup> Dental or vision cards grew in prevalence partly because traditional health insurance did not cover these benefits and separate insurance for such benefits was unaffordable for many. Employers and individual consumers purchased cards for the discounts.

<sup>2</sup> For example, Care Entrée, a large discount card company, has contracted with Private Healthcare Systems, Inc. (PHCS), a provider network company, providing enrollees with access to 400,000 physicians, hospitals, and laboratories, according to the company. See Precis Inc.’s U.S. Securities and Exchange Commission Form 10-k filing for fiscal year ending December 31, 2003, p. 5. AmeriPlan USA, a company that recently added discounts on physician services to its products (mostly dental and vision discounts), contracts directly with providers. Interview with Dennis Bloom, chairman and CEO of AmeriPlan USA, August 6, 2004.

<sup>3</sup> Precis Inc.’s U.S. Securities and Exchange Commission Form 10-k filing for fiscal year ending December 31, 2003. This company reports \$2.8 million in members’ escrow accounts in 2003.

<sup>4</sup> Interview with Dennis Bloom, chairman and CEO of AmeriPlan USA, August 6, 2004.

- <sup>5</sup> R. Kaiser, "Health Cards Fuel Mix-Ups," *Chicago Tribune Online Edition*, August 8, 2004, available at <http://www.chicagotribune.com> (visited August 9, 2004); L. Kalis, "Health Insurance: Working Without a Net," *Fortune Small Business*, May 22, 2004.
- <sup>6</sup> See K. Pollitz, R. Sorian, and K. Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, June 15, 2001).
- <sup>7</sup> Others believe that discount health plans qualify as creditable coverage. In fact, discount health plans do not qualify as creditable coverage and therefore consumers would not receive credit for this coverage to reduce an exclusion for a preexisting condition once they enroll in a health insurance plan.
- <sup>8</sup> In New York, a product called "Health-Flex 2000" is available for \$379/month for family coverage. This includes hospital indemnity insurance and a discount medical card for physician discounts. Information available at <http://www.artisthealthsource.org> (visited December 27, 2004).
- <sup>9</sup> Correspondence from Kathy Lannen, Executive Vice President, Best Benefits, to Mila Kofman, November 17, 2004.
- <sup>10</sup> *Precis Inc.'s U.S. Securities and Exchange Commission Form 10-k filing for fiscal year ended December 31, 2003*, pp. 3, 36.
- <sup>11</sup> An insurance agent interviewed for this paper reports that commission she was offered was 50% of the monthly fee charged for the discount card (not a one-time commission). Interview with Paula Wilson, October 1, 2004.
- <sup>12</sup> *Precis Inc.'s U.S. Securities and Exchange Commission Form 10-k filing for fiscal year ended December 31, 2003*, p. 35.
- <sup>13</sup> Multilevel marketing may add to substantial price increases. For example, a discount card offered by one company directly to consumers costs \$54.95 per month, while the same card sold by a marketer costs \$120 per month for the exact same network and benefits. See *In the Matter of U.S. Capital Healthcard BFT, Inc.*, Attorney General of the State of New York, Assurance of Discontinuance Pursuant to Executive Law §63(15), June 2002, p. 9. Several large companies interviewed for this report do not use network marketing. One sells its product to financial institutions, insurers, and other clients who then market the card to their existing clients or offer it as a free benefit, in the case of an insurance company client.
- <sup>14</sup> Telemarketing script for Healthcare Advantage sent to an insurance agent trying to recruit the agent to sell this product. (Script on file with authors.)
- <sup>15</sup> Some promoters send unsolicited faxes. Fax blasting is prohibited.
- <sup>16</sup> For example, the American Diabetes Association provided information on its Web page on a discount card called Care Entrée (available at <http://www.diabetes.org/home.jsp>, visited November 18, 2004). Costco, a wholesale club, also now offers a discount medical card to their members. Costco Web site available at <http://www.costco.com/Service/MemberService.aspx>, visited November 18, 2004. Discover credit card offers a discount medical card (information available at <http://www.discovercard.com/discover/data/products/planplus.shtml>, visited November 18, 2004). See also *In the Matter of U.S. Capital Healthcard BFT Inc.*, Attorney General of the State of New York, Assurance of Discontinuance, June 2002, p. 3 (Chamber of Commerce Association and Greater New York Chamber of Commerce promoted U.S. HealthCard).  
Some insurers offer discount cards as a free benefit to people covered by their health insurance policies. Such no-cost cards provide discounts on services not covered by insurance, e.g., plastic surgery. In some cases, insurers sell discount cards as standalone (without health insurance) products. Correspondence from K. Wrege of America's Health Insurance Plan to F. Dino, Chief Actuary, Office of Insurance Regulation, Department of Financial Services, Florida, October 18, 2004.
- <sup>17</sup> Kaiser, "Health Cards Fuel Mix-Ups," 2004.
- <sup>18</sup> High-pressure sales tactics are not new. The New York Attorney General's Office documented high-pressure tactics used by several discount card promoters in 2002. See *In the Matter of U.S. Capital Healthcard BFT Inc.*, June 2002, p. 8.
- <sup>19</sup> While reviewing state actions, we found that this company was shut down by Montana's insurance commissioner earlier in 2004 for not having provider networks and for operating illegally. *In the Matter of Continental Health*, Temporary Cease and Desist Order, Notice of Proposed Agency Action and Opportunity for Hearing, State Auditor's Office, Insurance Department of Montana. This company continues to operate and sells coverage in other states.
- <sup>20</sup> Through interviews with members of the Consumer Health Alliance we discovered that one of its members provided services for this discount card. Subsequent to our calls to participating providers, we asked the company for the discounted rates negotiated with these providers to compare our findings with the negotiated discounts. Because we did not have CPT codes, we could not accurately compare the savings.
- <sup>21</sup> A summary of the authors' experiences in contacting network providers is available from the authors upon request.
- <sup>22</sup> Of the 27 cards looked at initially, the price for some was as high as for health insurance policies; for example, one card's annual cost for single coverage would have been over \$1,200, and for family coverage over \$1,550.  
Additional research should be conducted to see if discount medical cards would provide value for uninsured people with ongoing medical needs. People who would be high users of health care (who are not able to negotiate discounts on their own) may realize a savings greater than the cost of the card. Also, families (with more than one user) may realize a value from a discount card. Additional research should also be done to determine whether someone who needs a surgical procedure and does not have insurance could benefit from a short enrollment (that is, if he or she can afford to pay the amount of the surgery in full).
- <sup>23</sup> See M. Kofman, K. Lucia, E. Bangit, *Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed* (New York: The Commonwealth Fund, August 2003).
- <sup>24</sup> Discussion with official from Florida Division of Financial Services, November 10, 2004.
- <sup>25</sup> There have also been reports of people on Medicare buying discount medical cards based on an erroneous belief that the discount card gets one a better rate and thus the coinsurance amount is less. Discussion with Bonnie Burns, California Health Advocates, November 15, 2004.
- <sup>26</sup> Report of the Maryland Insurance Commissioner Regarding Discount Card Plans, November 18, 2004. p. 2.
- <sup>27</sup> *In the Matter of US Capital Healthcard BFT Inc.*, Assurance of Discontinuance, New York Attorney General, June 2002, pp. 5, 9, 13-14; *In the Matter of Medisavers, Inc.* Assurance of Discontinuance, New York Attorney General, July 2002, p. 9.
- <sup>28</sup> Ibid.
- <sup>29</sup> Consumer Alert: "Bogus Medical Discount Plans: A Bitter Pill," U.S. Federal Trade Commission, February 2003.
- <sup>30</sup> G. Britton, "Discount Medical Plans and the Consumer: Health Care in a Regulatory Blindspot," *Loyola Consumer Law Review* 16 (2004): 97-99.
- <sup>31</sup> Eliot Spitzer, New York State Attorney General's Advertising, Marketing and Program Guidelines for Medical and Prescription Discount Cards, 2004.
- <sup>32</sup> See Kansas Insurance Department press release, "Commissioner Praeger and Attorney General Kline Unite to Fight Fraud," 2004.

- See also “Agreement between Florida Attorney General and MemberWorks Inc.” (settlement agreement), June 2004.
- <sup>33</sup> See “Summary Chart of State Medical and Pharmaceutical Discount Plan Laws and Regulations,” (Washington, D.C.: National Association of Insurance Commissioners, 2004).
- <sup>34</sup> Britton, “Discount Medical Plans,” 2004.
- <sup>35</sup> *Ibid.*, p. 114.
- <sup>36</sup> *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; *In the Matter of Continental Health et al.*, Case No. 2004-31, Temporary Cease and Desist Order, Notice of Proposed Agency Action and Opportunity for Hearing, State Auditor’s Office, Insurance Department of Montana, 2004; *In the Matter of All American Health Care et al.*, Case No.: 2004-33, Temporary Cease and Desist Order, Notice of Proposed Agency Action and Opportunity for Hearing, State Auditor’s Office, Insurance Department of Montana, 2004.
- <sup>37</sup> *State of Oklahoma v. Covenant Benefits Group, LLC*. Case No. 04-1610-DIS, Emergency Cease and Desist Order. 8 November 2004; *State of Oklahoma v. Lifeguard Benefit Services, Inc.*, Case No. 04-1611-DIS, Emergency Cease and Desist Order. 8 November 2004; *State of Oklahoma v. Quality of Life Health Corporation*, Case No. 04-1612-DIS, Emergency Cease and Desist Order. 8 November 2004.
- <sup>38</sup> Florida Statutes Title 37 Section Chapter 636 Part II (2004).
- <sup>39</sup> The National Association of Insurance Commissioners formed a working group, which held a public hearing on December 6, 2004 (information available at <http://www.naic.org>).
- <sup>40</sup> Interview with Dennis Bloom, chairman and CEO of AmeriPlan USA, August 6, 2004.
- <sup>41</sup> “Code of Conduct,” Consumer Health Alliance, 16 January 2003.
- <sup>42</sup> Interview with Kathy Lannen, Executive Vice President, Best Benefits, November 9, 2004.
- <sup>43</sup> Fifty percent of personal bankruptcies relate to a medical condition. Many consumers are at risk of having no financial security when lacking comprehensive health coverage. See M. Jacoby, T. Sullivan, E. Warren, “Rethinking the Debates Over Health Care Financing, Evidence From the Bankruptcy Courts” *New York University Law Review* 76 (May 2001): 377.

## STUDY METHODOLOGY

To test how well medical discount cards work, the authors enrolled in, used, and disenrolled from selected medical discount cards on the market in August, September, and October 2004. The researchers identified discount cards by searching the Internet; reviewing direct mail, fax, and e-mail solicitations; and reading advertisements and articles in magazines and newspapers. Additional vendors were identified through a trade association called the Consumer Health Alliance (CHA), which represents some companies that manage and administer discount cards.<sup>§</sup> Altogether, the researchers identified 27 discount medical card programs available to consumers nationally, according to their advertisement. (For a complete list, see [Appendix B](#).)

The researchers sought to enroll in cards that offered discounts for provider services in the greater Washington, D.C., area (including Virginia and Maryland). They could not enroll in some cards for the following reasons: disconnected telephone numbers; closed to new enrollment; no provider discounts (contrary to information in advertisements); no discounts in the greater D.C. area; or the cards were actually health insurance programs (contrary to information in advertisement). Additionally, they chose not to enroll in two cards because of prepayment requirements that were too high or too risky.<sup>§§</sup> Out of the nine cards remaining, the researchers selected five cards based on price range (i.e., \$25 and under, \$26–\$50, and over \$50 per month) and source of initial information (Web, fax, direct mail, etc.).<sup>§§§</sup>

<sup>§</sup> Some of CHA’s members offered to give us cards to test out. We chose not to because we wanted to go through a process that a consumer would go through in finding and choosing a card.

<sup>§§</sup> The number for this promoter was disconnected as of November 29, 2004.

<sup>§§§</sup> One limitation to testing our cards is that we did not use a bank account and thus could not test out whether there would be unauthorized withdrawals. During the enrollment process, we enrolled in one card under the researchers name, while enrolling under the researcher’s spouse’s name for the other four discount cards. Because this report’s researchers have published and have been quoted in the press on other research, we sought to avoid recognition as researchers. Hence, we used a researcher’s spouse’s name.

**Appendix A. Enrollment Information**

	Discount Card #1	Discount Card #2	Discount Card #3	Discount Card #4	Discount Card #5
<b>Initial Fees</b>					
Enrollment/other fees	\$90.00 <sup>a</sup>	\$10.00	None	\$50.00	\$120.00 <sup>a</sup>
Monthly fee	\$89.95	\$24.95	\$12.99 <sup>b</sup>	\$44.95	\$50.00
<b>Provider Network</b>					
List available prior to enrollment	No	Yes	Yes <sup>c</sup>	No	No
<b>Doctor/Hospital Services</b>					
Must pay physician at time of service	Depends on provider	Depends on provider	Yes	Yes	No
Must pay hospital at time of service	Unclear	No	No hospital discounts	Yes	Yes <sup>d</sup>
Waiting period for hospital services	No	30-day waiting period	No hospital discounts	No	No
<b>Marketing Tactics</b>					
Disclosure that this is not insurance	No	Yes	Yes	Yes <sup>a</sup>	Yes <sup>a</sup>
Pressure to enroll (e.g., offer will expire, price will increase, or open enrollment will soon end)	Yes	No	No	No	Yes

<sup>a</sup> There were inconsistencies between information received on the phone during the enrollment process with the information available on the Web site and/or in printed literature.

<sup>b</sup> Paid \$1.00 for first 60 days.

<sup>c</sup> The provider name was given as well as the toll-free number to find out who was in the network.

<sup>d</sup> Member must guarantee payment before any procedure. For hospital services, member must provide a guarantee of funds via certified funds if over \$2,000.

### Appendix B. Summary of 27 Discount Medical Cards

Discount Card	Source	Enrolled	Enrollment Fee	Monthly Fee Single/Family	Promised Savings	Discounts for Physicians	Discounts for Hospitals (No hospitals in Maryland)	Working (800) Telephone Number	Discounts in DC, MD, or VA	Accepting New Enrollees
1	Web	Yes	\$10.00	Refundable—\$24.95	15%–40%	Yes	No	Yes	Yes	Yes
2	Web	Yes	\$50	\$44.95	50%–80%	Yes	Yes	Yes	Yes	Yes
3	Web	No	Info. not available	\$79.95/\$99.95	Up to 80%	Yes	Yes	Yes	No	Yes
4	Web	No	No enrollment fee—special offer	Refundable—\$29.95	Up to 60%, (avg. savings are 21%)	Yes	No	Yes	Info. not available	Yes
5	Web	No	\$5.00	\$15.95	Up to 60%	Yes	Yes	No	Info. not available	Info. not available
6	Web	No	Info. not available	\$59.99	Up to 30%; at least 20% saving on doctors	Yes	Yes	Yes, but no info. over the phone	Info. not available	No
7	Web	No (Co. required medical info.)	Info. not available	\$84.95/\$99.95	Up to 66% on providers—nat. avg. is 30%	Yes	Yes	Yes	Info. not available	Yes
8	Web	No	\$70	Refundable—\$79.95/\$99.95	No claim about savings	Yes	Yes***	Yes	Info. not available	Yes
9	Web	No	\$20	Refundable—\$49	Up to 80%	Yes	Yes	No phone number	Info. not available	No
10	Web	No	\$15.00	Refundable—\$29.95	Up to 60%	Yes	Yes	No	Info. not available	Yes
11*	Web	Yes	\$120	\$50/\$90	Up to 80%	Yes	Yes***	Yes	Yes	Yes
12**	Web	No	\$28	\$148/\$337	Guaranteed savings of 20% off doctor visits	Yes	Yes	Yes	Yes	Yes
13	Web	No	\$10	Refundable—\$19.95	Up to 25% at provider's office	Yes	Yes	No phone number	Claims it is accessible in every U.S. state	Yes
14	Direct mail	Yes	None	Refundable—\$12.99 (Special offer of \$1 for first 60 days)	Up to 40%	Yes	No	Yes	Yes	Yes

Note: *Refundable* means that the plan will refund the enrollment fee and/or monthly fee if cancelled within 30 days of enrollment.

\* Inconsistent information (amount of enrollment fee and/or refund policy).

\*\* Contrary to its advertisement of a "medical discount card," an insurance product with pre-existing condition exclusions and a requirement to join an association. The enrollment fee includes a \$3 fee to the association and a \$5 billing fee is included in the monthly rate.

\*\*\* Waiting periods for hospital services, which means an enrolled person would not pay a discounted rate during a waiting period.

**Appendix B. Summary of 27 Discount Medical Cards (cont.)**

Discount Card	Source	Enrolled	Enrollment Fee	Monthly Fee Single/Family	Promised Savings	Discounts for Physicians	Discounts for Hospitals	Working (800) Telephone Number	Discounts in DC, MD, or VA	Accepting New Enrollees
15	E-mail	No	Info. not available	\$85	No claim about savings	Yes	Yes	No	Info. not available	Yes
16	E-mail	No	Info. not available	\$49/\$59	Up to 30%	Yes	Yes	No phone number	Yes	Yes
17	Interview	No	Info. not available	\$25 cap	10%–30%	Yes	Yes	Yes	Yes	Yes
18	Interview	No	\$100	\$89.95/\$109.95	No claim about savings	Yes	Yes***	Yes but no info. over the phone	Info. not available	Yes
19	Interview	No	Info. not available	\$69.95	15%–50% and sometimes more	Yes	Yes	N/A	Yes	Yes
20*	Fax	No	Refundable—\$149 (phone conversation)/\$199 (Web site)	Refundable—\$69	Up to 80%	Yes	Yes	Yes	No	Yes
21	Fax	No	Info. not available	\$99/\$129	No claim about savings	Yes	Yes	No phone number	Info. not available	Yes
22	Fax	No	Info. not available	\$99.95	No claim about savings	Yes	Yes	No	Info. not available	Yes
23	Fax	No	Info. not available	\$89.95	No claim about savings	Yes	Yes	No	Info. not available	Yes
24	Fax	No	Info. not available	\$79.95	No claim about savings	Yes	Yes	No	Info. not available	Yes
25	Fax	No	Info. not available	\$99.95	No claim about savings	Yes	Yes	No	Info. not available	Yes
26	Fax	No	Info. not available	\$89.95	No claim about savings	Yes	Yes	No	Info. not available	Yes
27*	Fax	Yes	Refundable—\$90	Refundable—\$89.95	Up to 80%	Yes	Yes	Yes	Yes	Yes

Note: *Refundable* means that the plan will refund the enrollment fee and/or monthly fee if cancelled within 30 days of enrollment.

\* Inconsistent information (amount of enrollment fee and/or refund policy).

\*\* Contrary to its advertisement of a “medical discount card,” an insurance product with pre-existing condition exclusions and a requirement to join an association. The enrollment fee includes a \$3 fee to the association and a \$5 billing fee is included in the monthly rate.

\*\*\* Waiting periods for hospital services, which means an enrolled person would not pay a discounted rate during a waiting period.

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