

What's New in Managed Care? Discount Plans?

Not Really: A Quarter Century of Statutory Divination, or,

The Birth of a Reg

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What's New in Managed Care? Discount Plans? Not Really: A Quarter Century of Statutory Divination, or, The Birth of a Reg

The Department of Managed Health Care (“DMHC” or the “Department”) on February 11, 2008, distributed to interested parties for comment a “preliminary draft” of regulations to control “discount plans” under the Knox-Keene Health Care Service Plan Act of 1975 (the “Act”).¹ This was but the latest related activity by the Department (under both its current and its previous appellation as the Department of Corporations), which has struggled for many years with what to do with “discount plans.” It is an interesting story for aficionados of health care public policy-making and regulation.

A. FRAMING ELEMENTS

1. Definitions. The preliminary draft defines a “discount health plan” as

(b) The term “discount health plan” means a person that, in exchange for a prepaid or periodic charge, paid by or on behalf of subscribers and enrollees, arranges for the provisions of access to health care services and products at rates that are discounted from the usual prices charged by health providers, and for which the subscriber or enrollee retains the financial responsibility to pay the provider for the discounted services rendered.²

A more detailed definition had been provided by the Department in 2001.³

Similar as they might seem, these two definitional platforms gave rise to opposite holdings regarding the applicability of the Act to discount plans.

2. In the Beginning: A Fiduciary Relationship. The Knox-Keene Act was passed in 1975 to regulate the then-nascent HMO industry. According to co-author John Knox, they were not sure where to house the administration of the Act. The Department of Health Services in those years was embroiled in several controversies and scandals swirling around the performance of certain Medi-Cal managed care programs (a Governor Reagan-era mechanism to contain Medi-Cal costs), so was not considered a good candidate. The authors saw their legislation as fundamentally protecting a fiduciary relationship: between the consumer, giving the HMO money in advance for the contracted availability of quality services when needed in the future, and the HMO, taking that advanced money and promising to be there when and if its system’s services came to be needed by the consumer. With the Department of Health Services, perhaps the more logical candidate, handicapped as the potential administrator, they settled on the department that primarily regulated and oversaw a range of marketplace fiduciary relationships, the Department of Corporations (the “DOC”).⁴

Although the DOC as HMO regulator fell out of favor with the Legislature, consumer advocates and the California Medical Association in the late 1990’s, giving birth to the DMHC as HMO regulator, that core fiduciary relationship grounded the policy analysis, inspired the

advocacy rhetoric, and, in spite of the extraordinary expansion of the Act over the years, remains the *raison d'être* of the regulation of HMO's – and of discount plans.

3. Construed Provisions. The Department's quarter-century of reckoning the nature and statutory status of discount plans has focused primarily on three provisions of the Act.

a. A "health care service plan" (the Knox-Keene name for an HMO; herein "HCSP") is defined in Health and Safety Code ("H&S") Section 1345(f)(1) as

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.

b. H&S Section 1375.1 mandates that every plan assume "full financial risk on a prospective basis for the provision of covered health care services."

c. H&S Section 1399.5 adds some gloss to the statutory activities of an HCSP:

It is the intent of the Legislature that the provisions of this chapter shall be applicable to any private or public entity or political subdivision which, in return for a prepaid or periodic charge paid by or on behalf of a subscriber or enrollee, provides, administers or otherwise arranges for the provision of health care services, as defined in this chapter, unless such entity is exempted from the provisions of this chapter by, or pursuant to, Section 1343. (emphasis added)

The divinations over the past quarter of a century have been to determine whether "arrange", "provision of", or "health care services" apply to discount plan arrangements and whether discount plans "assume full financial risk on a prospective basis." It hasn't been easy.

B. CURRENT EVENTS

After a hiatus of sixteen months of regulatory activity on discount plans (see below), in the wake of the collapse of the Grand Scheme health care reform legislative undertakings of the Governor and the Legislature, whether or not in *post hoc ergo propter hoc* causality, a flurry of events commenced in early February of 2008. (These actions take on richer meaning in the historical context sketched below.)

1. Opinions. On Friday, February 8, 2008, the Department issued two "Director's Opinions" (Nos. 08/1 and 08/2) finding that two discount plan entities had profiles that required that they be licensed by the Act.⁵ These two rulings were based on a Director's Opinion of

December, 2005, which had reinstated a Director's Opinion of 1983, by rescinding a Director's Opinion of 2001 that had overturned the 1983 Opinion.⁶

The February 2008 Director Opinions were in response to "requests for interpretative opinions" filed by two entities in June, 2005. As noted herein, much had happened on the discount plan front in the thirty-two months between the time the requests were filed and answered.

2. Regulations. On Monday, February 11, 2008, the Department distributed to interested parties and "stakeholders" for informal comments the preliminary draft discount plan regulations referenced above. The regulations declare that an entity that fits its definitional profile must secure licensure under the Knox-Keene Act as a "discount health plan", per the specifications of the proposed regulations.

They include detailed requirements (also some exemptions and a few statutory and regulatory waivers) regarding marketing and mandatory disclosures; bona fide discounts (curiously, only 50% of a network must offer discounts at least 10% below provider's UCR) and means for monitoring them; the availability and accessibility of providers and discounted services; tailored QA systems; complaint resolution mechanisms; cancellations and terminations; language assistance services; subscriber and enrollee disclosure forms; discount cards; subscriber and provider contracts; administrative and financial requirements (waives the requirement for the assumption of "full financial risk on a prospective basis for the provision of covered health care services"); and other similar requirements.

The draft regulations make no distinction between "full service" (*i.e.* medical) and "specialized" (such as dental, eye care, mental health, chiropractic, acupuncture) health care plans, although they prohibit medical discount plans from contracting with groups, only with individuals. However, discount plans would be required to pay "fees and reimbursements to the same extent as specialized plans." They also do not distinguish between entities that offer only "discount health plans" and Knox-Keene licensees that offer discount-plan-type products.

3. Legislation. On February 22, 2008, Senator Ron Calderon introduced SB 1603, to express the intent of the Legislature "to provide for the licensing and regulation of discount health care programs by the Department of Managed Health Care."⁷ The sponsor is "Consumer Health Alliance", a discount plan lobbying group thick in the fray over recent years.

4. Legislative Hearing. On March 27, 2008 (after deadline for this paper), the State Senate Health Committee conducted a regulatory oversight hearing on the DMHC, with "discount plan programs and regulation" being the lead topic.

C. THE PAST AS PRELUDE

These 2008 actions by the Department and the Legislature are the latest in a convoluted series that stretches back a quarter of a century.

1. Commissioner Franklin Tom's Opinion (OP 4614H). Although the Department had been asked from time to time about the applicability of the Act to structures similar to what

we today call discount plans, it was not until June 9, 1983 that the DOC issued a formal “Commissioner’s Opinion” – explicitly declared to be not an “interpretive opinion” – essentially holding that discount plans arranged for the provision of health care services.⁸ Under the targeted plan, for an annual membership fee a person would get discounted fees for medical, dental, vision services and prescription drugs from contracted networks of providers. Said the Commissioner, “...we conclude that the membership fee is a prepaid or periodic charge paid for, among other things, the arrangement of certain health care services.”

2. Dental Products in the 80’s. With the “arrange” prong of the discount plan test forged in the Tom Opinion, the Department for several years went to the brink with respect to the “assume full financial risk” requirement, in its authorizing a particular product to be offered by its licensee specialized dental plans. It was a quasi-discount product: typically, for a relatively small prepaid or periodic fee, the member had a right to an initial examination, cleaning and x-rays, and the same on some stated interval, usually annually, plus access to the plan’s network of providers to receive dental services at significantly discounted charges. The providers were obligated to provide the required services. (Orthodontics typically were not included.)

In the latter 1980’s, Department staff came to be nervous about these products, worrying that the plans were not assuming full financial risk for the discounted services. The plans countered that they were, since if their providers could not or would not provide the discounted services and so dropped out of the network, the plan would have to purchase at UCR rates the services it had contracted to provide. They also made collateral public policy and practical arguments in support of the product.⁹

The Department acceded to these arguments for several years, then after much dialogue with the plans and threatened regulations it recommended that they secure legislation to sanction their product. The suggestion was not pursued, and in the early 1990’s the Department let it be known that while it would “grandfather” the plans’ already approved “discount” arrangements, it would not approve additional ones.

3. The Interim: Discount Plan Creep. In spite of these early pronouncements (not exactly accessible to the entrepreneurial layperson), during the 1990’s discount plans crept into being, home-grown from California and out-of-state. The advent of the Internet greatly facilitated the promotion and marketing of such plans, which varied widely in their discount offerings, from medical to dental to vision to pharmacy, chiropractic, acupuncture and the like, packages of same and also in some offerings travel services, life insurance, and numerous other benefits. They seemed often to focus particularly on low-income, non-English-speaking and senior communities.

The Department at the time was heavily preoccupied and burdened during those years with trying to regulate the exploding licensed health care service plan industry, including presiding over the transformation of erstwhile non-profit plans into for-profit plans, typically leaving a handful of management personnel fabulously wealthy in a matter of months. At times it was besieged with criticism, as politicians and advocates rode the wave of public discontent with having their health care “managed” (read “restricted”), as it rapidly moved away from the indemnity to the managed care models.

In a resource-triage environment, discount plans were not a primary focus of enforcement concern for the Department, although the Department was involved in attempting to massage legislative bills aimed at discount plans in the late 1990's and early 2000's. Some preliminary steps were taken, and then set aside, to explicitly authorize Knox-Keene licensees, through regulation, to offer discount products as ancillary to their core offerings, a practice that in fact is tolerated to this day.

The California Civil Code, Section 1812.100 *et seq.*, since 1976 has had a detailed regulatory regimen for "discount buying organizations" yet, although arguably applicable, it has not been applied to health care services discount plans.

Moreover, H&S Code Section 445 has long forbidden the referral of a person for a fee to a physician, hospital or other such facility.¹⁰ But it was not until July 17, 2001, that the Attorney General issued Attorney General's Opinion No. 01/107, holding that "A corporation may not charge an annual subscription fee, including a reasonable profit, for furnishing a list of physicians willing to provide medical services at discounted rates to uninsured indigent persons." No mention is made in the AG's analysis of the Knox-Keene regulatory regimen – yet this represented a classic "discount plan" structure. The guardians of the common good and enforcers of the law seemed not to have been aware of one another.

4. Suddenly Zingale. Six weeks before the AG's Opinion was issued, the Director of the DMHC, Daniel Zingale, on June 7, 2001, rescinded the 1983 Franklin Tom Opinion, in Director's Opinion 01/1. He agreed that a discount plan fee constituted a "prepaid or periodic charge" under H&S 1345(f)(1), but distinguished between that section's "arranging for the provision of" health care services and a discount plan's "arranging for the provision of" discounts.

Regardless of how broad the term "arrange" may be used in the Knox-Keene Act, the fact remains that in the case of discount membership programs, the contract between the entity and its subscribers or enrollees (or person contracting on their behalf) does not "arrange" for the provision of health care services at all. Instead, arrangements for the provision of health care services are made directly between the member and the provider. The entity arranges only for a discounted rate for whatever health care services the member chooses to access on his or her own from a participating program provider.¹¹ (emphasis in original)

Director Zingale acknowledged that discount plans "raise a number of consumer protection concerns", naming several and dubbing them "significant issues." Regulation might be warranted, he suggested, but not under "the complex licensing and regulatory framework of the Knox-Keene Act", which he found to be "ill-adapted" to address these issues. Licensed plans could continue to offer discount products, however, under the regulation of the Department.

5. The Legislature Rises to the Challenge. A rash of legislative measures sought to regulate discount plans, all of them unsuccessful. By the time Director Zingale thought he had

taken the Department out of the discount plan regulatory business, two bills had already been introduced in 2000 addressing discount plans (SB 173 (Alpert) and SB 1181 (Polanco)).

One of the principal co-sponsors of the Alpert bill was First Dental Health, which in 2006 would be licensed as the first Knox-Keene discount plan. The Alpert bill declared:

These programs are not appropriately subject to regulation under the Knox-Keene Health Care Service Plan Act of 1975 [citation] because the programs do not arrange for the provision of health care services, do not assume the risk of payment for health care services and related products, and do not set limitations on the type or amount of services or products a consumer may obtain through the program.

This of course was virtually the same position subsequently taken by Director Zingale.

In 2002, SB 1461 (Speier) would have established a discount plan regulatory structure under the Attorney General's Office. That same year SB 2010 (Alpert and Polanco) started out as a bill to exempt discount plans from the physician referral prohibitions, then to do a study, then was gutted and used for another purpose. 2004 saw AB 2354 (Levine) addressing the referral prohibitions, but it too died.

2005 saw competing measures, one an industry measure, the other a bill seen as a vehicle for language that might emanate from the Department. The first, AB 1091 (Parra) was sponsored by the discount plan industry group "Consumer Health Alliance." It would have established a regulatory regimen under the Department but outside the framework of the Knox-Keene Act. Disclosure, bonding, complaint resolution requirements would have been coupled with regulations to be promulgated by the Department.

AB 1091 would have exempted discount plans from the provisions not only of the Knox-Keene Act, but also from the for-profit referral prohibitions that had been the focus of the AG's Opinion noted above, and also from the "discount buying organization" provisions noted above and from the state's anti-kickback provisions. This panoply of exemptions proposed by AB 1091 underscores the legal hazards under which discount plans operate in California.

The second 2005 measure, AB 562 (Levine), was less detailed, but lodged discount plans squarely within the framework of the Knox-Keene Act, laid out a handful of basic requirements and standards and required the Department to adopt regulations to flesh out the program. Notably, AB 562 would have prevented a discount plan from offering medical services (the "basic health services" of H&S Section 1345), "including any service provided by a physician."

In March Parra and Levine had set aside their differences and agreed to co-author a common bill, "stakeholder" meetings were convened, but eventually they agreed to hold off and let the Department proceed with its regulation-crafting already underway. The Department proceeded that summer to hold a number of stakeholder/public meetings to receive input on its projected regulation of discount plans.

In 2006 Assembly Member Perra was back, with AB 2855, which would have required discount plans to be licensed pursuant to regulations to be issued by the Department. It also would have exempted all Knox-Keene plans from the anti-referral provision of Business and Professions Code (“B&P”) Section 650 and from the anti-referral provisions of the H&S Section 445, discussed above. The bill stalled in the first committee, it being known that the Department by this time was working on regulations – although the measure had originated with the Department.

Finally, beyond the Legislature, the National Association of Insurance Commissioners (NAIC) for many months had been working through numerous drafts that came to closure in August, 2006 as the “Discount Medical Plan Organization Model Act .” It was an interesting but not dispositive document.

D. THE DEPARTMENT GOES ON THE OFFENSIVE

1. Pressure Builds. Following the Zingale Opinion, discount plan activity accelerated in California. Big Brother supposedly would no longer be hanging around. The Internet, television and other mediums were used to promote offerings and schemes that were varied and often attractive. Many of the purveyors were out-of-state operations, some of dubious identity, substance and integrity. By nature of the product, they were oriented primarily at people who had no health care coverage for one or another service. Some of the offerings proved to be illusory, some of the schemes were outright scams. The reality and legitimacy of the discounts represented and of the provider networks promised, the quality controls exercised, as well as deceptive promotional and sales tactics and a range of unscrupulous practices by some discount plans were blights on the model.

Complaints began to pour in to consumer protection offices, local DA’s offices, the Department and the Legislature. The media did not miss the stories. The bills noted above were responses. Estimating that there were approximately one hundred discount plans operating in the state, the Department became proactive, yet was burdened with the Zingale Opinion. It nevertheless began to investigate plans being complained about.

2. The Department Acts, *pace* Zingale. In September of 2004 the Department put out in English and Spanish a strong “*Consumer Alert* Discount Health Plans” bulletin “warning”(“beware”, “be on guard”) that “discount plans can be hazardous to your pocketbook” and offering tips on how to assess a plan.¹² (Italics in original)

That same month the Department issued Cease and Desist Orders against two discount plans, Platinum Health Plan (based in Florida) and Family Health, for engaging in fraudulent and deceptive marketing practices – but also because “the arrangement of health care services without a license [is] in violation of California law.” “.....because they refer consumers to specific providers, they must be licensed by the DMHC....”¹³ In January of 2005 the Department ordered Platinum to have all its advertising approved in advance by the Department and also to get a Knox-Keene license. The Department again asserted, in reference to discount plans as a category, “...because they are arranging for the provision of health care services, they

must be licensed by the DMHC under California law.”¹⁴ Platinum has yet to file its application for licensure.

This “constructive abandonment” of the Zingale Director’s Opinion that discount plans were not covered by the Knox-Keene Act was a stimulus to the 2005 legislation noted above.

By the summer of 2005, the Department had launched with fanfare an expanded enforcement offensive, issuing Cease and Desist Orders against a number of discount plans, for a range of offenses, and requiring them to secure Knox-Keene licensure if they wished to continue in operation.¹⁵ All but one have yet to apply.

The Department was bold in its assertion of jurisdiction over the plans and of its right to be cracking down. Given the Zingale Opinion and the ambiguous posture of the Department over the years towards discount plans, and the on-going felt needs of members of the Legislature to grant the Department such jurisdiction and establish various regulatory regimens for discount plans, it was to be expected that one of the targeted discount plans would challenge the Department’s jurisdiction.

E. CAPELLA FIGHTS BACK

1. Initial Skirmishes. A discount plan known as “Care Entrée” a dba of “The Capella Group” was one of the 2005 Cease and Desist recipients.¹⁶ A Texas outfit, it engaged in a range of shady promotional tactics, but had a particular wrinkle, that members had to establish and fund an escrow account with an affiliate of Capella, and no discounted medical services could be rendered unless there were sufficient funds in the account at the time the services were needed. The funds were used to pay for members’ medical needs and for unpaid membership fees. This feature was not conspicuously advertised or clearly explained and so was found to be an “illusory” benefit. The Department also saw Care Entrée suggesting that its product was insurance.

The Department found that the Care Entrée practices violated a number of provisions of the Knox-Keene Act. The Department asserted its jurisdiction on the grounds that Care Entrée was “undertaking to arrange for the provision of health care serviced to members, either directly or through arrangements with others, in return for a periodic charge paid by the members, within the meaning of [H&S] Code section 1345(f)(1).” The Capella Group decided to challenge that assertion of jurisdiction.

A series of legal maneuvers ensued. Initially, in September, 2005, Capella filed a request for an administrative hearing on the issue, which was granted.¹⁷ In November the Department issued an order staying portions of the July 15th Cease and Desist Order.¹⁸ Capella subsequently filed an action in Superior Court to challenge the Department’s jurisdiction, asserting that the administrative hearing would be useless since the Department had already made up its mind.¹⁹

2. Zingale no More, Tom Back. Upping the pace and intrigue of the regulatory drama, bracing for the Court proceedings and preparing for the administrative hearing, the Department on December 14, 2005, in a four-line “Notice of Rescission” devoid of analysis or explanation, rescinded the Zingale Opinion (2001) and reinstated the Franklin Tom Opinion

(1983), summarily unburdening itself of that stark if nominal contradiction and potential cloud on its numerous actions already filed against discount plans.²⁰

3. Capella is Heeled. The court on March 13, 2006, denied Capella's motion, telling Capella that it must exhaust its administrative remedies before resorting to the judicial system.²¹ Capella and the Department then entered a Stipulation to limit the scope of the administrative hearing to the issue of jurisdiction.²² (The case would ultimately be dismissed, on Capella's motion, given this relegation of the matter to the administrative forum.)

That hearing was held in three sessions in February and March of 2006; the proposed decision was released on June 15, 2006.²³ Capella struck out. Noting the extensive activities of the Care Entrée program, which included its escrow fund requirement and its management of those funds, re-pricing and payment of claims, its actual referrals and arranging for appointments, its provision of advice through a "nurse help line", the Administrative Law Judge took an expansive interpretation of "arrange for the provision of services", asserting without citation the assumed intent of the authors of the Act and extending it to the Capella discount plan model. The ALJ dismissed the "assumption of full financial risk" requirement as being not intrinsic to the question of whether a discount plan entity were operating as a plan.

The ALJ found a common thread between HMO's, insurance coverage and discount plans in that they all "connect the member to the participating provider" and all provide "discounts" in that they do not have to pay full rates. "Capella and similar programs are subject to Knox-Keene because they arrange for the provision of health care services." Thus, the fundamental formula equating the arranging for a discounted fee with the arranging for the provision of services.

In fairness, invoking H&S Section 1344(c), the ALJ's Proposed Decision excused Capella from actual penalties because it had legitimately and in good faith relied on the Zingale Opinion in operating without a license.

On September 26, 2006, the Capella resistance ended. The Department adopted the ALJ's decision, with one minor modification,²⁴ and simultaneously entered into a Consent Agreement with Capella.²⁵ It required Capella to apply for a Knox-Keene license and kept it on a very short leash with respect to marketing, shutting down its escrow program, revising a number of its operational aspects and materials, requiring periodic reports, and the like. Capella agreed not to challenge the Department's jurisdiction over its discount program in any judicial, administrative or other forum.

Capella came to file its licensure application on April 4, 2007, and it is still in process a year later.

F. SECURING THE ZONE

The Department moved swiftly to underscore its newly-affirmed jurisdiction and to formalize the regimen for discount plans.

1. A Precedent Decision. On October 2, 2006, it declared that the Capella administrative decision just adopted would be elevated to the status of a “Precedent Decision” under Government Code Section 11425.60.²⁶ In its declaration, the Department explained that a “precedent decision” is one that “contain[s] significant legal or policy findings that apply beyond the facts of the particular case.” In case there were any doubt.

2. The First Discount Plan License. Shortly thereafter, on October 10, 2006, the Department issued its first licensure of a discount plan under the Knox-Keene Act, of First Dental Health (FDH).²⁷ FDH had not been an enforcement target but in mid-2005, observing the Department’s aggressive discount plan campaign and gauging the future, had made the business judgment to seek licensure, which pleased the Department. In uncharted waters, the Department and FDH collaboratively and carefully worked out an application within the Knox-Keene template. It included a number of “not applicable” acknowledgements and several waivers. It was sensitively calibrated to the realities of the discount plan model and of the needs for enrollee protections. Both teams were aware they likely were creating a future regulatory framework.

In December, 2007, the Department and FDH kicked off a joint “public health education campaign designed to address the availability and need for accessible dental care for the nearly 15 million dentally uninsured Californians.” The campaign is focusing on families and seniors, and intends to offer throughout the state “free oral health assessments” and to raise awareness of the correlation between oral health and overall health.”²⁸

Its Knox-Keene license designates FDH as a “discount specialized health care service plan.” Today the Department does not list FDH as a discount plan on its website, merely as a dental specialized plan.²⁹

3. Current Events. As sketched above in Section “B”, after a breather of many months, the 2008 surge finds draft regulations, more Director’s Opinions, more legislation and a legislative hearing all “teed up” for yet another season of deliberations on discount plans.

G WHITHER DISCOUNT PLANS?

Clearly this protracted regulatory *novella* is not over yet. The draft regulations will have to run their formal course to promulgation, which can be an ordeal. The powerful California Medical Association has already expressed its scorn:

CMA has serious reservations about the legitimacy of discount health plans in California. Not only do we believe that they are illegal, but we also remain unconvinced that DMHC has jurisdiction to regulate them. Also, from a public policy perspective, we believe they bring little value to consumers, as the benefit they purport to provide is illusory at best.”³⁰

The CMA also cited the AG’s Opinion described above as concluding that the discount health plan business model was illegal under California law. Rather than issuing regulations, the CMA urged the DMHC “to enforce the law and to stop the deceptive and illegal marketing of these “health plans” in California.”

The Legislature may yet be interested in intervening, though one suspects this remains a messy one the solons may be glad to let the bureaucracy handle. The CMA or the discount plan lobby could work to thwart the promulgation of the proposed regulations. Some determined discount plan may take a run at a judicial overrule of the Department's current hold on jurisdiction, but it is hard to see a court wanting to enter this thicket, especially with regulations in the works.

Left unanswered in the preliminary draft regulations are the anti-referral obstacles of B&P Section 650 and H&S Section 445. The Department-backed AB 2855 of 2006 explicitly exempted discount plans from these statutory provisions.

Will aspirants step forward to be licensed? Will the discount plan model become prominent? To the extent they do, it may be more in the specialized areas such as dental and vision rather than in the full-spectrum medical arena. Services are so expensive in the latter that one who is unable to or unwilling to secure more standard "coverage" may conclude that the discounts in the end do not make the services that much more affordable. Services in the specialized arena are of a very different order of cost magnitude, the services intrinsically more affordable, discrete, predictable and preventable.

Perhaps the discount plan model will come to be partnered and offered with other structures such as high-deductible and catastrophic products, possibly in tandem with health savings accounts. At the least, with the legitimization and controls that should follow from public licensure, the discount plan structure may become a safer option for product planners and for employers.

The discount plan model may prove to be an alternative for employers too financially strapped to offer more standard managed care or indemnity products to their employees but wanting to offer some sort of help towards meeting their health care needs.

And in the uncharted future of health care delivery system reform it may be that the discount plan model will be a working piece of a puzzle that yet seems incapable of being put together, some modest contribution to enabling some portion of the uninsured to get some care.

¹ DMHC, "Preliminary Draft, Proposed Adoption of [Title 28, CCR Article 2.5]", electronically distributed to interested parties, February 11, 2008 ("[Preliminary Draft](#)"); the Act is found at Health & Safety Code Section 1340 *et seq.*

² Preliminary Draft 26 CCR 1300.49.1.2(b)

³ "The common attributes of these discount membership programs are that they (1) charge fixed-rate periodic membership fees, generally monthly or annual, without regard to the volume of health care services, if any, accessed by the member; (2) arrange for members to receive discounts on health care services received from plan providers; (3) provide their members with lists of participating plan providers; and (4) are not involved in the member's decision to access providers or the provision of health care services. All contracts for health care services are formed directly between the member and the provider. Program providers bear sole responsibility for providing the health care services, and members bear sole responsibility for payment of the discounted fees for the services. The programs typically promise only that members will receive a discount on the fees charged by participating providers for any services the member may choose to seek." [DMHC Director's Opinion 01/1](#)

⁴ Personal conversations with author Knox

5 http://www.dmhc.ca.gov/aboutthedmhc/gen/gen_cfd.asp
6 See below, sections C-1 and E.
7 Proposed SB 1603, Section 1(g); http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_1601-1650/sb_1603_bill_20080222_introduced.pdf
8 <http://www.dmhc.ca.gov/library/regulations/discount/CommOp4614H.pdf>
9 Besides, insisted the plans, this product represented good public policy, since it enabled those who could not otherwise afford dental care to get it, asserting that there were in excess of 400,000 enrollees so benefiting. Moreover, this form of “shared responsibility” was especially apt to dental care, since it incentivized people to take care of their teeth, dental care being different from medical or vision care, which are needed for conditions not so under the control of the individual. It also was a way for the plans to cut down on the phenomenon of “in-and-out” “dirty mouth” enrollment, in which people would sign up for a plan with major, serious dental work needed, the result of years of neglect, get the care, and then disenroll as soon as possible. This is contrary to the premise of prepaid care, in that many people pay in and have an open-ended right to care, over time of paying in, if and when they need it. Not all do, so the cost risk is spread out and the enterprise is actuarially viable. When people can sign up for a plan, have the wreckage of years of neglect fixed and then not renew, the actuarial picture gets skewed. In effect, the arrangement becomes a reverse discount plan for the “in-and-outer.”
10 “No person, firm, partnership, association or corporation, or agent or employee thereof, shall for profit refer or recommend a person to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition. The imposition of a fee or charge for any such referral or recommendation creates a presumption that the referral or recommendation is for profit.” (H&S Code Section 445)
11 The Director explained further, “This conclusion is consistent with the substantive provisions of the Knox-Keene Act as well as with its jurisdictional definition of a “health care service plan.” The comprehensive licensing and regulatory framework of the Knox-Keene Act is directed at ensuring that entities which accept responsibility for providing and paying for health care services needed by their subscribers and enrollees have the financial solvency and administrative capacity to provide access to those services in a manner that ensure their quality and continuity.

Discount membership programs, on the other hand, provide no health care services, pay for no health care service, and assume no responsibility for the quality of any care provided to their members by participating providers. Their only promise to members is that participating provides have agreed to make their services available to plan members at discounted rates. The requirements of the Knox-Keene Act which regulate the quality of care offered by health plans are therefore inapplicable to them. A member who is dissatisfied with the care received from a participating provider has recourse to the appropriate licensing authority for that category of health service provider.

Similarly, since the program undertakes no financial obligation to pay for members’ care, its financial insolvency does not threaten the members’ access to care or the program providers’ ability to provide it. If a discount membership program becomes insolvent, the member can still continue to access the same care through the same providers, albeit at the non-discounted fee. The maximum financial loss to the member in the event of insolvency is the amount of the most recent membership fee payment. The requirements of the Knox-Keene Act which regulate the financial solvency of health care service plans are therefore largely inapplicable to discount membership programs.”
12 <http://www.dmhc.ca.gov/library/reports/news/DiscHPAlert.pdf>
13 <http://www.dmhc.ca.gov/library/reports/news/DiscHPPREN.pdf>
14 <http://www.dmhc.ca.gov/library/reports/news/DiscPlansPR.pdf>
15 http://www.dmhc.ca.gov/library/enforcements/discount/enf_discount.asp
16 <http://www.dmhc.ca.gov/library/enforcements/actions/cgi/16540.pdf>
17 See fn 25
18 See fn 25
19 See docket calendar at [https://www.lasuperiorcourt.org/CivilCaseSummary/main.asp?Referer=Index;Complaint,TheCapellaGroupInc.v.CaliforniaDepartmentofManagedCare,No.BC341633\(LASuperiorCourt,Oct.18,2005\)](https://www.lasuperiorcourt.org/CivilCaseSummary/main.asp?Referer=Index;Complaint,TheCapellaGroupInc.v.CaliforniaDepartmentofManagedCare,No.BC341633(LASuperiorCourt,Oct.18,2005))
20 <http://www.dmhc.ca.gov/library/regulations/discount/Recission.pdf>

21 See docket calendar at <https://www.lasuperiorcourt.org/CivilCaseSummary/main.asp?Referer=Index>; The
Capella Group Inc. v. California Department of Managed Care, No. BC341633 (LA Superior Court, March
13, 2006) (order denying preliminary injunction)

22 See fn 25

23 <http://www.dmhc.ca.gov/library/reports/news/carep.pdf>

24 <http://www.dmhc.ca.gov/healthplans/gen/pdecisions/ccgi.pdf>

25 <http://www.dmhc.ca.gov/library/enforcements/actions/cgi/21060.pdf>

26 http://www.dmhc.ca.gov/healthplans/gen/gen_precedent.asp

27 First Dental Health, Health Care Service Plan License (File No. 933-0435) (Dept. of Managed Care Oct.
10, 2006)

28 Press Release, First Dental Health and Department of Managed Care, Public Education Campaign Targets
High Price of Dental Coverage (Dec. 5, 2007) (available at
<http://www.firstdentalhealth.com/AboutUs/PressReleaseDec0507.asp>)

29 <http://wpso.dmhc.ca.gov/hpsearch/details.aspx?id=933%200435&name=&page=all>

30 <http://www.calphys.org/html/cc623.asp>