



# Michigan Association of Health Plans

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To: Rep. Marc Corriveau

From: Rick Murdock, Executive Director

Date: March 31, 2009

Re: MAHP response to House hearing questions

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**Question 1: In Michigan, can a commercial carrier raise an individual policyholder's rate at renewal based on asking questions about the person's health at renewal, i.e. "re-underwriting?"**

**Answer: No.** Both HIPAA and Michigan statute MCL 500.2213b require that individual health insurance policies be guaranteed renewable at the option of the insured. Here is a textbook definition of guaranteed renewability:

A guaranteed renewable [health insurance] policy is one by which the insurer guarantees to renew the policy to a stated age, such as age 65. The policy cannot be canceled, and renewal of the policy is at the insured's sole discretion. Although an individual insured cannot be singled out for a rate increase, the insurer has the right to increase premium rates for the underwriting class in which the policy is placed."

Although this textbook definition is not in Michigan law, MCL 500.2020 expresses the principle that underlies it. This section is entitled "Unfair methods of competition or deception; unfair discrimination in accident or health insurance" and states in pertinent part:

The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance: Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, membership, or policy fees, or rates charged for any policy or contract of accident or health insurance applicable to individual or family expense coverage or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever."

Also, in a 2001-2002 survey conducted in connection with an article published in Health Affairs, the Michigan insurance regulator answered "No" to the question "Can the carrier increase premiums on an individual policy at the time of renewal based on the individual's claims history?"

Here's the link to the source of the textbook definition and the survey information:

<http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.280v1/DC1>

**Question 2: In Michigan, are commercial insurers allowed to use durational rating and block-closing for individual health policies?**

**Answer: No.** In a 1993 final administrative decision in the matter of Golden Rule Insurance Company that was later upheld in court, the Michigan Insurance Commissioner found that durational rates are unfairly discriminatory because members of an insurance pool are charged different rates even though they do not necessarily have different underlying risk characteristics. Durational rating occurs when a carrier knowingly establishes the initial premium for an individual health insurance policy at an unsustainably low level that will require substantial rate increases on future renewal dates. The initial premium is unsustainable because the longer someone is in an insurance plan, the greater is the likelihood they will become ill - even if they are healthy when they take out insurance.

If an insurer does not keep adding new members to one larger pool, but instead closes out entry into existing pools and divides new applicants into new pools, rates in the "closed blocks" will rise because risk is not broadly shared. The Insurance Commissioner found that this practice violates MCL 500.2020. The 1993 final decision is In the Matter of Golden Rule Insurance Co., Petitioner, No. 90-10830-R. This matter was referenced at: [http://www.familiesusa.org/assets/pdfs/Disc\\_brief\\_summary350f.pdf](http://www.familiesusa.org/assets/pdfs/Disc_brief_summary350f.pdf)

**Question 3: What protection is there in Michigan law against wrongful rescission and post-claims underwriting? How big a problem is this in Michigan?**

Section 3408 of the Insurance Code requires all individual health insurance policies to contain a provision that after two years from the date of policy issue, no misstatements, except fraudulent misstatements, made by the applicant in the policy application may be used to void the policy or to deny a claim for loss incurred after that two year period. By itself, this section of law does not prohibit an insurer from waiting until an insured files a claim within the first two years a policy is in effect, analyzing the accuracy of statements made on the application, and then denying the claim based on alleged misstatements in the application.

However, Chapter 20 of the Insurance Code contains unfair trade practice provisions that can be used to challenge wrongful rescission and post-claims underwriting. These provisions include MCL 500.2026(1)(f) - failing to attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear, 2026(1)(a)- misrepresenting pertinent facts or policy provisions, 2026(1)(c)- failing to adopt and implement reasonable standards for the prompt investigations of claims, 2026(1)(d)- refusing to pay claims with conducting a reasonable investigation and 2026(1)(n)- failing to promptly provide a reasonable explanation of the basis in the policy or in relation to the facts or law for denial of a claim. The California and Connecticut Insurance Departments have used similar provisions in their state laws to successfully challenge wrongful coverage rescissions in their states.

It is difficult to tell how big a problem wrongful rescission is in Michigan. The National Association of Insurance Commissioners (NAIC) maintains a database of closed complaints that can be searched by company and reason for the complaint. A search of 2007 and 2008 records for several large writers of individual health insurance in Michigan found zero (0) complaints with the reason code "rescission." The link to the database is: <https://eapps.naic.org/cis/>

In testimony before the House Committee on Oversight and Government Reform in July 2008, Stephanie Kanwit, Special Counsel for America's Health Insurance Plans testified that rescission is rare, occurring in only two-tenths of one percent of cases. Her testimony also included seven consumer-centric rescission principles endorsed by AHIP's board of directors. Her testimony can be accessed through:  
<http://oversight.house.gov/documents/20080717113640.pdf>

The NAIC's Health Insurance and Managed Care Committee is looking into the issue of wrongful rescissions. Through its Regulatory Framework Task Force, it is surveying industry and regulators to determine the scope of the problem. It is studying the following: typical grounds for rescissions or disputed exclusions, whether there are any existing internal company processes and standards currently applied to rescission or pre-existing condition exclusion decisions, and whether there are any existing state laws, case law, and regulations on the issue. The Task Force anticipates completing this analysis and preparing an informational paper on its findings and recommendations by June 2009.