Summary BRIEF

The Illusion of Group Health Insurance: Discretionary Associations

March 2004

Discretionary associations are dues-paying membership organizations that often exist primarily to sell insurance policies. These associations differ from other types of membership associations, such as professional, trade, and labor organizations, that may also offer insurance as a member benefit—discretionary associations typically offer few services apart from selling health insurance to their members. In contrast, other kinds of membership associations generally provide a range of member services that may include educational opportunities, training, conferences, and lobbying.

Health insurance sold through discretionary associations is generally promoted and marketed as *group* coverage. Consumers typically seek group health insurance because they believe it provides low-cost, high-quality, continuous coverage. In reality, discretionary associations simply give insurance carriers a way to market *individual* health insurance policies under the guise of offering group insurance.

This Issue Brief identifies troublesome insurance business, marketing, and consumer protection problems in the discretionary association marketplace and suggests a number of regulatory and legislative approaches to address them. The principal problems described in this Issue Brief include:

1. Discretionary associations and insurance carriers use marketing methods that tend to mislead consumers about basic issues like coverage and premiums. One prevalent practice, the use of "teaser" rates, fosters the illusion of low premiums.
2. Insurance carriers in this market use predatory rating and aggressive underwriting practices that charge much higher prices to policyholders who are older, who are sick, or who have a medical history that includes illness or injury.
3. Many states do an inadequate job of policing the business, rating, and marketing practices in this sector of the insurance market. These insurers tend to base their operations in states with the weakest regulatory protections.

As a result, when consumers who are seeking low-cost health insurance that appears to offer group protections purchase discretionary association health insurance, they are often hit with enormous, unadvertised rate increases and end up being priced out of this market and otherwise uninsurable.

Possible solutions to these problems include the following:

- State laws should require that associations represent the interests of their members and not the interests of insurers.
- State regulators should review and, if necessary, overhaul their insurance disclosure requirements.
- State regulators should ensure that discretionary associations are compatible with the expectations that policyholder have about group insurance.
- State consumer protection laws should be amended to allow consumers to challenge unfair rating and business practices in state court.
- State legislators and regulators should prohibit certain patently unfair rating and business practices.

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Robbie and Shirley Collins were offered health insurance through Eagle Consumer Association, a nonprofit association with almost 40,000 members.[1] At $168 a month, the policy was less expensive than equivalent coverage offered by the state's Blue Cross and Blue Shield carrier. So the Collins family paid $90 in annual dues to join Eagle Consumer Association. They thought they had a good deal. What they didn't know was that Eagle Consumer Association was founded by the insurance company that issued their policy. A few years later, the family was hit with three rate increases over the course of seven months, pushing the monthly premium for the couple and their two young sons up to $451, nearly three times the original premium.[2]

This story provides an all-too-common example of what happens to consumers who buy what is referred to as *discretionary association* health insurance. This segment of the health insurance market continues to grow as people who lose their traditional employer-based insurance seek low-cost alternatives that seem to promise group protections.[3] It is also a reflection of the spotty and largely inadequate regulatory system that is supposed to oversee this sector of the market. This system allows association carriers to find safe haven in states that are relatively permissive where rate setting and other important forms of regulation are concerned without running much risk of being stopped by other states with stronger regulations.

This issue brief points to abuses in the marketing, sale, and rating practices of the discretionary association health insurance market and suggests some possible solutions to these problems. We hope it will encourage state legislators and insurance regulators to initiate corrective measures in this market.

FamiliesUSA
The Voice for Health Care Consumers

About this Issue Brief

This issue brief will discuss the following topics:

1. What are discretionary associations?
2. How do discretionary associations differ from other membership associations?
3. How does health insurance offered by discretionary associations differ from traditional group health insurance?
4. How big is the discretionary association market, and who plays in it?
5. What are the problems with discretionary association health insurance?
    - In general, discretionary associations function with little statutory or regulatory oversight.
    - Discretionary associations use marketing methods that mislead consumers.
        - They appear to represent their members' interests, but, in fact, they are under the operating control of insurers.
        - They are marketed as providing group health insurance, but their practices are inconsistent with traditional group insurance.
        - They fail to disclose material information about benefits and costs.
    - They typically engage in aggressive underwriting and rating practices.
        - They use teaser, or durational, rating without disclosing that such rates are promotional and time-limited.
        - They use closed blocks of business.
        - They re-underwrite at renewal.
6. What are some solutions to these problems?
    - State laws should require that associations represent the interests of their members.
    - State regulators should review and potentially overhaul their insurance disclosure requirements.
    - State regulators should make sure discretionary associations are compatible with policyholder expectations about group insurance.
    - State consumer protection laws should be amended to allow consumers to challenge unfair rating and business practices in state court.
    - State legislators and regulators should prohibit certain patently unfair rating and business practices.

1. What are discretionary associations?

Discretionary associations are dues-paying membership organizations that 1) often exist primarily to sell insurance products and 2) function as master policyholders for health insurance issued to their members. They are typically organized as not-for-profit organizations or trusts. In some cases, they are created by insurance companies to market insurance policies.

2. How do discretionary associations differ from other membership associations?

Discretionary associations differ from other types of membership associations, such as professional, trade, and labor organizations, that may also offer group insurance as a member benefit.

- Discretionary associations typically have limited purposes (and offer few services) apart from selling health insurance to their own members who, unlike participants in professional and similar groups, have little in common apart from enrollment in an insurance pool.[4] In contrast, professional, trade, and labor membership associations generally provide a range of services to their members that may include educational opportunities, training, conferences, and lobbying.
- Individuals must join the discretionary association on a dues-paying basis as a condition of insurance eligibility. However, discretionary associations often exclude members in poor health.
- While discretionary associations may seem to deal with the insurance carriers that contract with them at arm's length, insured people and independent analysts have raised substantial questions about their independence, corporate purpose, and allegiance to members.[5] *The Wall Street Journal* has provided evidence that association members, i.e. insurance policyholders, typically have little or no say in association policy, including the selection of insurance vendors.[6] In some instances, the associations are formed by, and operate as, creatures of insurance companies. Insurance brokers and agents working for the carrier often take association membership applications and accept and remit association dues.[7]

3. How does health insurance offered by discretionary associations differ from traditional group health insurance?

Discretionary association health insurance is generally marketed and promoted to potential enrollees as *group coverage*. Selling a product advertised as "group coverage" is advantageous because people tend to equate group insurance with low cost and better value.[8] Discretionary association health insurance is particularly attractive to individuals who are not otherwise eligible for group coverage, such as people who are self-employed, out of the job market, or working without health insurance.

In reality, however, discretionary associations permit insurance carriers to market *individual* health insurance policies as if they were group policies. These individual policies are typically medically underwritten, which allows health insurance carriers to "cherry pick" the healthiest people while declining to cover those who are sick. (**Medical underwriting** is the process insurance companies use to determine whether to accept an applicant for coverage and what the terms of the coverage will be, including the premium. This process takes into account such factors as age, current health conditions, and medical history.)

4. How big is the discretionary association market, and who plays in it?

While no precise data are available on overall enrollment levels, the scope of the market, or financial performance, a series in *The Wall Street Journal* estimated that at the end of 2002, in Georgia and Florida alone, over 2 million people were insured through discretionary associations or similar arrangements.[9]

Golden Rule,[10] MEGA Life, Mid-West National Life, American Medical Security Group, Provident Indemnity Life, American National Life of Texas, and Philadelphia Life are among the carriers that have been actively involved in this segment of the health insurance market.[11] Discretionary associations like the Federation of American Consumers and Travelers (FACT), the National Association for the Self Employed (NASE), Concerned Health Care Users of America, and the Alliance for Affordable Services, have participated in the insurance sector as master policyholders for a number of years.[12]

5. What are the problems with discretionary associations?

Discretionary associations often exist with little statutory or regulatory oversight, use marketing methods that mislead consumers, and engage in aggressive underwriting and rating practices.

- **In general, discretionary associations function with little statutory or regulatory oversight.**

  State regulatory oversight of this market has been largely inadequate. Carriers have been able to find safe haven in states that are permissive where setting rates and other important forms of regulation are concerned.[13] Discretionary associations are unlikely to be stopped by other states with stronger regulations because insurance departments tend to defer to the state where the association is domiciled. (Where an association is "domiciled" is generally the place where an organization [as a corporation] is chartered or the place that is the organization's principal place of business.[14])

  In some cases, this may be explained, in part, by the inadequacy of a state's legal jurisdiction. In the 1970s and 1980s, states recognized that associations offering insurance to their members across the country potentially faced 50 sets of conflicting laws.[15] The solution most states adopted was to exempt these associations from many regulations, especially when it came to setting rates.[16] According to an expert at Georgetown University's Health Policy Institute, at least 25 states grant these association carriers complete or partial exemption from restrictions on what they charge policyholders.[17] In addition, almost 40 states have laws that say that as long as the association wasn't established solely to sell insurance, it can be exempted from many state laws.[18]

  However, in other cases, states have adequate jurisdiction but have been reluctant to exercise the enforcement powers they do have. In a 1995 test of state jurisdiction, a federal court held, in *Golden Rule v. Stephens*, that Kentucky could apply its renewability standards and rating principles to a discretionary association (FACT) domiciled out of state (in Illinois). The insurer's claim that Kentucky lacked regulatory jurisdiction over an out-of-state master policy was not accepted by the court, which had little difficulty finding that Kentucky could apply its insurance laws to the insurance certificates held by FACT members living in Kentucky.[19]

- Discretionary associations use marketing methods that mislead consumers.

  - **They appear to represent their members' interests, but, in fact, they are under the operating control of insurers.** Discretionary associations have been criticized as being under the operating and financial control of the insurers they endorse instead of their consumer members.[20] As a practical matter, this means that vendor selection and performance review, premium issues, benefit design, and other important facets of the insurance business that have a daily impact on association members are not subject to independent, consumer-oriented oversight.

    For example, *The Wall Street Journal* extensively documented the fact that the NASE, one of the largest discretionary associations, is and has always been a creature of its insurance carrier.[21] In addition, UICI,[22] the parent company of MEGA Life and Mid-West National Life, settled a Kansas case for $1 million when a lawsuit alleged that the company had "implemented a fraudulent marketing scheme" by intentionally representing to consumers that it was independent and had negotiated the best possible deal for consumers in health insurance.[23]

    State laws that define the necessary characteristics of discretionary associations have generally failed to ensure the independence and loyalty of the associations to their members.[24] These laws generally require a minimum time in business, or they require that members can join the association without purchasing insurance. In addition, because discretionary associations are not directly in the "business of insurance," they generally fall outside the regulatory purview of state insurance departments.

  - **They are marketed as providing group health insurance, but their practices are inconsistent with traditional group health insurance.** Discretionary associations have often misled consumers by claiming or implying that their health insurance is group coverage. For example, litigants in a recently filed action against MEGA Life and its discretionary association, NASE, claim that NASE's Web site states that "the group negotiating power of NASE makes it possible to offer valuable benefits to our members. One of these benefits is access to health insurance coverage." It also alleges that the insurer's sales force

misrepresents the insurance policy "as being 'group insurance' available only to NASE members and obtained at significant savings because of the association's 'group' buying power."[25]

The term "group insurance" conveys important information and creates certain expectations among ordinary consumers seeking non-employment based health insurance in the marketplace. Among other things, it connotes: (1) relatively low cost coverage over the life of the policy (compared to individual, non-group insurance) as a result of group selling, renewal, and administrative transactions; (2) comparatively stable year-to-year premiums due to the effects of broad-based group risk spreading; (3) long-term rate stability resulting from deliberate measures to prevent adverse risk selection (including, for example, continuous enrollment of new group members.); and (4) the sophisticated health insurance expertise of a large purchaser.[26]

The insurance offered in the discretionary association market is fundamentally inconsistent with the group insurance label. In contrast with the so-called "true" group insurance market (including job-based insurance), long-term prices in the discretionary association sector tend to be volatile, risks are segmented rather than widely dispersed, pricing practices *encourage* adverse risk selection, and insurance benefits tend to be limited.

◆ **They fail to disclose material information about benefits and costs.** Policyholders have claimed that various carriers in the discretionary association market fail to disclose material information they need to make informed enrollment choices, including important details about costs and benefits.

Some discretionary association products provide limited benefits packages yet fail to disclose this information to prospective customers.[27] For example, the benefits structure of the typical policies sold by UICI (which sells association policies in 38 states and owns Mega Life & Health Insurance Co. and Mid-West National Life Insurance Co.) are particularly limited.[28] Many UICI policies cap hospital room and board benefits at $300 to $400 a day when the average costs are $700 a day. Most group policies offered by other companies pay nearly all of a patient's expenses after copayments and deductibles.[29]

- They typically engage in aggressive underwriting and rating practices.

  Aggressive underwriting and rating practices, such as the use of durational rating, block closing, and re-underwriting at renewal (all described below), would be impermissible under the individual health insurance laws of many states but are pervasive in the discretionary association health insurance market.

  Some states and private litigants have sought corrective action.[30] However, legal challenges based on a theory of unfair or discriminatory rating practices like these (e.g. consumer class actions) run the risk of being denied on the basis of the "filed rate doctrine." The filed rate doctrine holds that "any rate–that is, one approved by the governing regulatory agency–is per se reasonable and unassailable in judicial proceedings brought by ratepayers."[31] Thus, if insurance rates have been approved by regulators, consumer plaintiffs may be without standing to sue, even if their challenges include allegations of fraud, conspiracy, breach of contract, or some other basis common to insurance disputes. (Note, however, that the filed rate doctrine may not be an impediment in all jurisdictions. In one recent case, a federal district court determined that the filed rate doctrine did not apply to the business of long-term care insurance.[32])

  - **They use teaser, or durational, rating without disclosing that such rates are promotional and time-limited.** Carriers in the discretionary association market have frequently adopted a durational rating approach. This approach features promotional level—teaser—premiums at entry followed by much higher renewal rates.[33] Policyholders have claimed that this rating structure is not meaningfully disclosed to them in sales literature, policy brochures, or through other channels.[34] As a result, they are blindsided by steep renewal rate hikes.

  The durational rating method is based on the insurer's expectation that a pool of healthy, newly medically underwritten individuals (in concert with an insurance policy incorporating waiting periods, pre-existing illness exclusions, deductibles, and other cost-sharing features) will predictably support low rates during some initial (two-three year) time period. After that, it is assumed that the impact of medical underwriting will wear off: The initially "very healthy" pool of policyholders will begin to

look more and more "average" as it ages and gets sicker, and policyholders will begin to file more claims. Since insurance carriers normally base their premiums on an estimate of anticipated claims' costs years into the future, renewal premiums are raised in advance to reflect underwriting wear-off.

This durational rating method has been challenged by private litigants and prohibited on different grounds in several states.[35] For example, litigants have challenged teaser rates as being undisclosed, unfair, and deceptive. Their claim is that carriers knowingly establish initial premiums at unsustainable, low levels for marketing purposes without notifying consumers that their approach to rate setting will necessitate substantial rate increases on future renewal dates.[36] In addition, in Michigan, the insurance department concluded that durational rates were unfairly discriminatory because members of an insurance pool were charged different rates even thought they did not necessarily have different underlying risk characteristics.[37]

- **They use closed blocks of business.** Various carriers in the discretionary association market have adopted, as standard practice, the periodic closure of existing risk pools to new policyholders. In effect, when these carriers judge a particular group of policies to be less profitable than desired, they stop marketing the policy to prospective new enrollees. This practice is called *closing a block of business*. Existing policyholders are adversely affected by this practice because they are deprived of the additional spreading of risk that would come from the addition of new, medically underwritten enrollees. The result is that, as policyholders in the closed block grow older and sicker, the renewal rates levied upon them begin to mount, and an inevitable upward spiral, widely known as a *death spiral*, is set in motion. The spiral accelerates as the healthiest members of the pool relinquish their coverage, leaving a smaller pool of sicker policyholders to bear all of the insurance costs. Closing a block of insurance is another example of a practice that is incompatible with the risk-spreading features of group insurance.

- **They re-underwrite at renewal.** Re-underwriting is a method used to divide a group of policyholders into two or more health-related subgroups and then charge individuals

renewal premiums based on claims experience, diagnoses, and other factors. "Healthy" policyholders may receive token rate increases, while those assigned to a less healthy category may be charged considerably more.[38]

A *Wall Street Journal* article indicated that one company, American Medical Security Group, assigned subscribers to one of three premium tiers. The healthiest subgroup—the so-called preferred tier (about 40 percent of all subscribers) had no health and claims factors built into their renewal premium, so they saw no health and claims rate increase. The middle tier (also comprised of 40 percent of all subscribers) got a 5 percent health and claims increase. The bottom tier (the remaining 20 percent of subscribers) had a 37 percent health and claims increase.[39]

The practice of medically re-underwriting individuals at the point of renewal is inconsistent with the basic principles of group insurance risk spreading. [40] Also, in a class action brought by subscribers, a Florida court found that the practice violated state law and breached the group insurance contract.[41]

6. What are some solutions to these problems?

- State laws should require that associations represent the interests of their members.

  Discretionary associations are often under the *de facto* operating and financial control of the insurers they endorse instead of their consumer members.[42] State laws should assure that discretionary associations serve as agents for their members in the selection of carriers, negotiation of the provisions of the master policy (including rates and coverage), administration of the policy, renewal, and re-contracting, etc.[43] Associations should be assigned those legal responsibilities and liabilities set forth in state laws dealing with the duties of fiduciaries or quasi-fiduciaries. (A fiduciary is someone who has the power and obligation to act for another [often called the beneficiary] under circumstances that require total trust, good faith, and honesty. A fiduciary must avoid "self-dealing" or conflicts of interests in which the potential benefit to the fiduciary is in conflict with what is best for the beneficiary.[44]) By clarifying the role of the associations as fiduciaries for their members, suitable legal obligations would prevent conflicts of interest.

- State regulators should review and potentially overhaul their insurance disclosure requirements.

  The marketing methods and sales practices used by insurance carriers in the discretionary association market have often not been transparent or sufficient to permit informed consumer decision-making. States differ dramatically with respect to the scope and specificity of their disclosure requirements. They also differ widely as to their general approach to disclosure.[45] Insurance departments should review, clarify, and, if necessary, strengthen their product disclosure requirements. In so doing, they should be especially mindful that inexperienced consumer audiences often have a very hard time understanding insurance terminology and making meaningful use of insurance concepts and data. State insurance departments should also use existing tools available to them to test the impact of disclosures on consumer comprehension. Available tools include targeted market conduct examinations, special examinations, and informational and rulemaking proceedings.

- State regulators should make sure discretionary associations are compatible with policyholder expectations about group insurance.

  Some states already define and regulate health insurance issued through discretionary associations as individual insurance.[46] In general, individual health insurance arrangements receive added scrutiny. Other states have proposed adopting comparable oversight.

  Where states are not inclined to treat discretionary association business as individual insurance, the state insurance department should determine, pursuant to existing state unfair insurance practice laws and regulations, if the association carrier's actual business practices are compatible with the ordinary expectations of consumers regarding the benefits of "group insurance." To implement this policy, insurance departments should require carriers issuing discretionary association coverage to file annual actuarial certifications of underwriting and rating practices and use this information as part of an active regulatory process for monitoring and enforcing fair marketing practices.[47]

- **State consumer protection laws should be amended to allow consumers to challenge unfair rating and business practices in state court.**

  In some states, misleading representations in insurance–including material non-disclosures that have a tendency to create false impressions in the eyes of the consumer–violate both general state consumer protection laws (so-called mini-FTC laws) and state unfair insurance practice laws.[48] However, in most instances, consumers have no standing to bring causes of action under the insurance laws and/or to recoup financial damages. In some states, such as Massachusetts, however, a violation of the state unfair insurance practices law is also considered, *de facto,* an infringement of the state consumer protection statutes. The consumer protection law permits policyholders to seek injunctive relief and monetary damages up to and including treble damages for unfair and deceptive acts and practices in the business of insurance.[49] States should ensure that consumers have standing to sue by amending their consumer protection laws to ensure that a violation of the insurance law is automatically a violation of the consumer protection law.

- **State legislators and regulators should prohibit certain patently unfair rating and business practices.**

  Aggressive underwriting and rating practices permeate the discretionary association health insurance market. States should prohibit teaser or durational rating, block closing, and re-underwriting at renewal in the discretionary association market.[50]

  Some states already prohibit closing blocks of business, and certain courts have found that this practice violates guaranteed renewability requirements. If block closing is permitted, states should consider requiring insurers to blend the experiences of current enrollees with that of enrollees in open blocks of insurance as a surrogate for permitting the insurance pool to refresh itself with new members. For example, California restricts block closing and requires that the actuarial experience of closed blocks or pools of business be blended with open blocks.[51] In addition, a federal court found that this tactic violated the Kentucky Health Care Reform Act's guaranteed renewability requirement. The court stated, "It is critical to understand that the above quoted

policy provisions do not require the company to cancel all policies in the state to divest itself of insureds that have become risky. Rather, the company need only cancel the policy form for a given block of business. As a result, the average life of a Golden Rule health policy is three years. Therefore, to describe Golden Rule's policies as 'guaranteed renewable' is at best highly illusory."[52]

Further, the practice of re-underwriting at renewal is contrary to the policy adopted by the National Association of Insurance Commissioners (NAIC) and is inconsistent with NAIC Model Laws governing the individual market.[53] In addition, 19 states already have strict rating laws.[54] Florida recently passed legislation to clarify that when an out-of-state group insurance carrier segments risks by separating healthy policyholders from unhealthy ones, thereby resulting in a "death spiral," it engages in unfair discrimination and therefore an unfair trade practice.[55] And a state court found health-related renewal underwriting to be inconsistent with group insurance.[56]

Conclusion

The discretionary association market may continue to grow as individuals, unable to access traditional employer-based insurance, seek low-cost alternatives that appear to promise group protections. This issue brief points to the abuses in this market and provides some possible solutions to these problems. We hope it will encourage consumer advocates, state legislators, and insurance regulators to work together to investigate the impact of discretionary association health insurance on consumers and to develop legislative and regulatory safeguards and consumer protections for this market.

Endnotes

[1] The Eagle Consumer Association was founded by Central Reserve Life Insurance Co. Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Dearls Are Often Set Up by Insurers," *The Wall Street Journal*, November 21, 2003.

[2] Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Deals Are Often Set Up by Insurers," op. cit.

[3] Mila Kofman, *Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed*, The Commonwealth Fund (August 2003).

[4] The New York State Insurance Department requires that members of a discretionary association share either enterprise, economic, or social affinity. NY Code of Rules and Regulations, Regulation 62, Title 11, Part 52.

[5] Second Amended Complaint, Robert Pride, et.al. v. MEGA Life and NASE, No. 2002-349 (Miss. Cir. Ct. 2d. Jud. Panola County, 2003) on file with IMR Health Economics, LLC; Notice of Pendency of Class Action, Proposed Settlement and Settlement Hearing, DeBrooke et. al. v. United Benefit Life Ins. Co. and American Association for Consumer Benefits, No. 96-02-550-A (Tex. 107th Jud. Cameron City, 1997) on file with IMR Health Economics, LLC; Garcia v. MEGA et. al. No. DC-03-135 38 (Tex. Jud. Starr County 2003) on file with IMR Health Economics, LLC.

[6] Individuals who are insured through discretionary associations are sometimes referred to as "certificateholders" to distinguish them from the association itself, which is the "policyholder."

[7] UICI Press Release, "UICI Announces Purchase of UICI from Gregory T. Mutz," (May 8, 2003).

[8] DeVetter v. Principal Life Ins. Co., 516 N.W.2d 792 (Iowa, 1994); among other advantages recently cited by discretionary association policyholders, "Golden Rule's website portrays the health insurance it markets to FACT members … as providing 'group benefits' including stable premiums that would increase only if overall costs of the entire group increased, without regard to individual health history." Initial Complaint John Crichton, et. al. v. Golden Rule Ins. Co., No. CA 02-L-20 (Il. 3d Cir. Madison Co., 2002) on file with IMR Health Economics, LLC.

[9] Chad Terhune, "Association Health Carriers Face Stricter Rules by Insurance Panel," *The Wall Street Journal*, December 12, 2002 and Chad Terhune, "States Probe Health-Policy Sales Promoted through Associations," *The Wall Street Journal*, February 25, 2003.

[10] UnitedHealthcare purchased Golden Rule Financial Corp. in November 2003. "UnitedHealthcare Cutting Some Individual Health Coverage," *St. Louis Business Journal*, Jan. 13, 2004.

[11] Florida Department of Insurance, Division of Insurance Consumer Services.

[12] Ibid.

[13] In some cases, for example, carriers are merely required to file group rates with the domiciliary insurance department on an informational basis, which deprives the insurance department of the opportunity to conduct any meaningful review.

[14] Find Law.com (http://dictionary.lp.findlaw.com/), viewed February 17, 2004.

[15] Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Deals Are Often Set Up by Insurers," op. cit.

[16] Ibid.

[17] Chad Terhune, "Association Health Carriers Face Stricter Rules by Insurance Panel," op. cit.

[18] Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Deals Are Often Set Up by Insurers," op. cit.

[19] Golden Rule v. Stephens, 912 F. Supp. 261 (D. Ky. 1995).

[20] Second Amended Complaint, Robert Pride, et.al. v. MEGA Life and NASE, No. 2002-349 (Miss. Cir. Ct. 2d. Jud. Panola County, 2003) on file with IMR Health Economics, LLC; Notice of Pendency of Class Action, Proposed Settlement and Settlement Hearing, DeBrooke et. al. v. United Benefit Life Ins. Co. and American Association for Consumer Benefits, No. 96-02-550-A (Tex. 107th. Jud. Cameron City, 1997) on file with IMR Health Economics, LLC.

[21] Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Deals Are Often Set Up by Insurers," op. cit.

[22] UICI is a company that offers a broad range of health insurance products for self-employed individuals and individuals who work for small businesses; (http://www.uici.net), viewed December 15, 2003.

[23] Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Deals Are Often Set Up by Insurers," op. cit.

[24] Second Amended Complaint, Robert Pride, et.al. v. MEGA Life and NASE, No. 2002-349 (Miss. Cir. Ct. 2d. Jud. Panola County, 2003) on file with IMR Health Economics, LLC.

[25] First Amended Complaint and Motion for Class Certification, Frank Garcia and Cynthia Alaniz et. al. v. MEGA Life and NASE et. al,

No. DC-03-135. (Tex. D. Ct. 381st Jud. Star County 2003) on file with IMR Health Economics, LLC.

[26] Holmes and Rhodes, *Appleman on Insurance* (2nd edition); Gregg, D., "Fundamental Characteristics of the Group Technique" in Eilers, R. and R. Crowe, *Group Insurance Handbook* (1965); Life Insurance Co. of N.A.v. Commonwealth Insurance Department, 402 A2d 297, 298 (Pa. 1979) upholding rejection of a putative "group policy" form found by regulators to be inconsistent with group underwriting principles.

[27] Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Deals Are Often Set Up by Insurers," op. cit.

[28] Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Deals Are Often Set Up by Insurers," op. cit, and Chad Terhune, "States Probe Health-Policy Sales Promoted through Associations," op. cit.

[29] Chad Terhune, "Nonprofit Groups That Tout Insurance Have Hidden Links: Associations That Offer Deals Are Often Set Up by Insurers," op. cit.

[30] Plaintiff's Second Amended Complaint, Crichlow v. Torchmark Corp., No. 4-96-cv-086-HLM, (D.N.D. 1997) on file with IMR Health Economics, LLC; Final Judgment on Liability, Addison et. al. v. American Medical Security, No. CL 00-01445 (Fla. Cir. Ct. 15th Jud. Palm Beach Co., 2003) on file with IMR Health Economics, LLC; Michigan Insurance Bureau, Final Decision in the Matter of Golden Rule Insurance Co., Petitioner, No. 90-10830-R (1993) on file with IMR Health Economics, LLC.

[31] Wegoland Ltd. V. NYNEX, 27 F.3d, 17, 18 (2d Circ. 1994); also see, Mt. Sinai Medical Center v. Empire BCBS, 724 NYS 2d 23 (N.Y. App. Div. 2001).

[32] See Kanner, Alan, "The Filed Rate Doctrine and Insurance Fraud Litigation," 76 N.D.L. Rev. 1 (2000), for a thorough discussion of a recent decision, Hanson v. Acceleration Life Insurance Co. WL 33283345 (D. N.D. 1999).

[33] This is sometimes styled as "select and ultimate" pricing.

[34] Initial Complaint, John Crichton, et. al. v. Golden Rule Ins .Co., No. CA 02-L-20 (Il. 3d Cir. Madison Co., 2002) on file with IMR Health Economics, LLC.

[35] In Plaintiff's Second Amended Complaint, Crichlow v. Torchmark Corp., No. 4-96-cv-086-HLM, (D.N.D. 1997) on file with IMR Health Economics, LLC., insureds alleged fraud on the part of the carrier for knowingly and intentionally setting initial rates at "grossly inadequate" teaser levels without disclosing the scale of expected future adjustments. Plaintiff's Seconded Amended Complaint, No. 4-96-cv-086-HLM, (D.Ga. 1997). The matter was reportedly settled, confidentially, for $55 million. See (http://www.insure.com/health/torchmark399.html). Second Amended Complaint, Robert Pride, et.al. v. MEGA Life and NASE, No. 2002-349 (Miss. Cir. Ct. 2d. Jud. Panola County, 2003) on file with IMR Health Economics, LLC.

[36] For example, Initial Complaint, John Crichton, et. al. v. Golden Rule Ins .Co., No. CA 02-L-20 (Il. 3d Cir. Madison Co., 2002) on file with IMR Health Economics, LLC; Frank Garcia and Cynthia Alaniz et. al. v. MEGA Life and NASE et. al, No. DC-03-135. (Tex. D. Ct. 381st Jud. Star County 2003) on file with IMR Health Economics, LLC.

[37] Michigan Insurance Bureau, Final Decision in the Matter of Golden Rule Insurance Co., Petitioner, No. 90-10830-R (1993) on file with IMR Health Economics, LLC.

[38] Renewal rates for policyholders who filed claims amounting to more than 80 percent of their paid premium were increased by 413 percent by a carrier in the discretionary association market. Hogue v. United Olympic Life Ins. Co. 39 F. 3rd 98 (5th Cir. 1994).

[39] Chad Terhune, "Health Insurer's Premium Practices Add to Profit Surge, Roil Customers," *The Wall Street Journal*, April 9, 2002.

[40] Families USA, *Protecting Consumers from Unfair Rate Hikes*, available online at (http://www.familiesusa.org/site/DocServer/Rate_Hikes_Revised_Feb_2003.pdf?docID=342), (Washington: February 2003).

[41] Addison et. al. v. American Medical Security, No. CL 00-01445 (Fla. Cir. Ct. 15th Jud. Palm Beach Co., 2003) on file with IMR Health Economics, LLC.

[42] Mega Life, NASE Group and NASE are under common control and ownership and operate as a unified business arrangement. First Amended Complaint and Motion for Class Certification, Frank Garcia and Cynthia Alaniz et. al. v. MEGA Life and NASE et. al, No. DC-03-135. (Tex. D. Ct. 381st Jud. Star County 2003) on file with IMR Health Economics, LLC, but in other cases, the relationship between the insurer and the association is contractual.

[43] In some states, a master policyholder is regarded as the agent of the carrier issuing the coverage for various purposes. In most cases, however, it is not. Eugster, S., "Group Insurance: Agency Characterization of the Master Policy-Holder", 46 *Washington Law Review* 377 (1971).

[44] Law.com (http://dictionary.law.com/), viewed February 5, 2004.

[45] This topic is explained at length in Kirsch, Larry, "Do Product Disclosures Inform and Safeguard Policyholders?" 20 J. *Insurance Regulation* (3) Spring 2002.

[46] Utah and Iowa are among those states that do so. Private communication from state insurance departments on file with IMR Health

Economics, LLC.

[47] A recent court decision finding tier rating (in a discretionary association health insurance context) to be inconsistent with group insurance principles. Addison et. al. v. American Medical Security, No. CL 00-01445 (Fla. Cir. Ct. 2002) on file with IMR Health Economics, LLC. On the other hand, insureds failed to convince the court in Hogue v. United Olympic Life Ins. Co., 39 F3rd 98 (5th Cir. 1994) that dividing a pool into two "claims-based" classes for purpose of establishing renewal rates was unfairly discriminatory. (The "sicker" class faced a 413 percent rate increase.)

[48] Every state has adopted the model unfair insurance practices statute promulgated by the National Association of Insurance Commissioners (or a variant of the model). See, for example, Massachusetts General Laws, c.176D.

[49] Sula Dodd v. Commercial Union Insurance Company, 373 Mass. 72, 365 N.E. 2d 802 (Mass. 1977). MA Gen Laws c.176D and c.93A.

[50] For example, Wisconsin has declared durational rating to be unfair, predatory, and contrary to public policy. See Wisconsin Administrative Code, Section 6.67 Insurance.

[51] See, Ca. Ins. Code, section 10176.10 (1999).

[52] Golden Rule v. Stephens, 912 F. Supp. 261 (D. Ky. 1995).

[53] The Small Employer and Individual Health Insurance Availability Model Act (Model #35) provides for adjusted community rating, and health status is not one of the factors that can be used to set rates. The Individual Health Insurance Portability Model Act (Model #37) provides for the use of rating characteristics, and health status is not one of the listed characteristics. More specifically, that model also provides that changes in health status after issue, and durational rating, are not to be used in setting premiums for individual policies. NAIC Memo To All Members, re: Reunderwriting in the Individual Health Insurance Market, July 17, 2002 (Kansas City, MO).

[54] The term "strict rating laws" means the use of community rating or rating bands. Community rating laws prohibit health plans' use of experience, health status, or duration of coverage in setting premium rates. Rating bands restrict how much variation health plans are allowed when setting premium rates based on these factors. State Individual Market Insurance Reform Laws. Blue Cross Blue Shield Association, (Washington: December 2001).

[55] Florida, SB 2264, Effective July 1, 2003, amending the out of group statute (s 627.6515 F.S.), available online at (http://www.fldfs.com/companies/Memoranda/OIR-03-012m.doc).

[56] Addison et. al. v. American Medical Security, No. CL 00-01445 (Fla. Cir. Ct. 2002) on file with IMR Health Economics, LLC.

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