STATE OF MICHIGAN

OFFICE OF FINANCIAL AND INSURANCE REGULATION (OFIR)

Report on the Limited Scope Market Conduct Examination of

American Community Mutual Insurance Company

Livonia, Michigan

For the Period January 1, 2007 through December 31, 2007

NAIC COMPANY CODE: 60305

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December 23, 2008

Honorable Ken Ross
Commissioner of Insurance
Office of Financial and Insurance Regulation
State of Michigan
611 West Ottawa St.
Lansing, MI 48933-1070

Dear Commissioner Ross:

Pursuant to Section 500.222, Michigan Statutes, the Michigan Office of Financial and Insurance Regulation (OFIR) has called a target market conduct examination of

American Community Mutual Insurance Company

at its home office located at:

39201 Seven Mile Road
Livonia, Michigan 28152-1094

The following report thereon is respectfully submitted.

HISTORY AND PROFILE

American Community was founded in the spring of 1938 when the Michigan Hospital Benefit Association was formed (later changed to the American Hospital-Medical Benefit Association). American Community was the first insurer in Michigan to market Individual and Group hospital-surgical insurance plans.

Community Life Insurance Company was formed in 1947 to market life insurance. For a number of years, the American Community and Community Life companion companies functioned as separate corporations operated by the same staff in the same location. In 1958, the life company changed its name to American Community Mutual Insurance Company (Company) and in 1964 the two companies merged.

The Company's home office is located in Livonia, Michigan, and their market product portfolio includes Individual and Group Managed Care, Group Major Medical, Short Term Medical, Health Savings Accounts, Dental, Group Vision and Weekly Income. The Company sells their products in Arizona, Arkansas (individual only), Illinois, Indiana, Iowa, Michigan, Missouri, Nebraska, Ohio, Oklahoma (individual only), Tennessee (individual only), Texas (individual only) and Wisconsin (individual only).

METHODOLOGY

This examination is based on the standards and tests for a Market Conduct Examination of a Health Insurer found in the *NAIC Market Regulation Handbook.* The utilization of this Chapter reflects Michigan Insurance Statutes, Rules and Regulations.

The types of review used in this examination fall into three general categories. The types of review are: generic, sample, and electronic. Some standards were measured using a single type of review, while others used a combination or all of the types of review.

A "generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the *NAIC Market Regulation Handbook.* For statistical purposes, an error tolerance of 10% was used for reviewed samples. The sampling techniques used are based on a 95% confidence level. This means that there is a 95% confidence level that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn. Note that the statistical error tolerance is not indicative of the OFIR's actual tolerance for deliberate or systemic error.

An "electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a particular type.

The sampling methodology described in the *NAIC Market Regulation Handbook* generally calls for a sample of 100 files when the file population being sampled exceeds 5000. This was the case in samples developed for this examination.

SCOPE OF EXAMINATION

The State of Michigan's Office of Financial and Insurance Regulation ("OFIR") or ("the Department") conducted a target market conduct examination of American Community Mutual Insurance Company ("ACMIC") or ("the Company") for the period of January 1, 2007 to December 31, 2007. The examination was called pursuant to Section 500.222 of the Michigan Statutes. The market conduct examination was conducted at the direction of, and under the overall management and control of, the market conduct examination staff of the Department. Representatives from the firm of INS Regulatory Insurance Services, Inc. were engaged to complete certain agreed upon procedures.

The examination reviewed the Company's activities related to its health insurance complaints handling and claims handling practices. Attention was focused to determine if all complaints and claims are investigated appropriately and in compliance with Michigan Statutes.

Each business area has standards that the examination measured. Some standards have specific statutory guidance, others have specific Company guidelines and yet others have contractual guidelines. Please note that some business areas in the *NAIC Market Regulation Handbook* do not have a Michigan statutory basis and have not been included in this examination. The product lines reviewed in this examination were health insurance products.

This examination was limited in scope. Review was confined to Standards in the following business areas:

Complaint Handling;
Grievance Handling; and
Claims.

This examination report is a report by exception rather than a report by test.

EXECUTIVE SUMMARY

Several significant issues were noted by the examiners in the following business areas. They include:

- One file (G-3) contained a grievance relating to the Company's decision to rescind the insured's health insurance policy. The examiners did not agree with the actions of the Company in this matter as they violated the "Time Limits" provisions in the contract as well as Michigan statute MCL § 500. 2005(i).
- The Company's acknowledgement of grievances contained an incorrect citation of the Michigan Code. ACT, MI ACT 571 regarding their rights and the Company's responsibilities associated with grievances. The Company acknowledged that their communications must reference the Michigan Code. MI ACT 251.
- The Company failed to pay Emergency Room claims relating to illnesses according to Michigan statute MCLS§ 500.2026(f) (failure to settle claims when liability is reasonably clear).
- The examiners find that the Company's acceptance of health insurance applications for processing without medical history is an unsuitable practice under Michigan statute MCLS§ 500.2005(a).
- The Company failed to adequately underwrite applications before the issuance of individual health insurance policies. Additionally, the Company performed significant underwriting actions to new individual health policies after experiencing claims. The result of this activity was to rescind health insurance policies and deny claims. These findings represent unfair trade practices as defined in MCL § 500.2002 and may be subject to regulatory action under provisions of MCL § 500. 2043.
- The Company failed to maintain discrete complaint and grievance files. Additionally, the Company failed to maintain adequate documentation in the complaint files provided to the examiners;

Complaints/Grievances

Overall Synopsis of Grievance and Complaint Reviews:

Observations: The Company has established written individual and group grievance procedures for policyholders. These procedures include four subgroups; internal and external standard reviews as well as expedited internal and external reviews. The Company distinguishes between the terms grievance and complaint. A complaint is an expression of dissatisfaction transmitted to the Company from the OFIR or another regulatory entity. A grievance is a complaint received by the Company directly from a customer or the customer's representative.

Standard 1

The health carrier treats as a grievance any written complaint submitted by or on behalf of a covered person regarding: (1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a covered person and the carrier.

Observations: The Company has established written individual and group grievance procedures for policyholders. These procedures are broken down into four subgroups; internal and external standard reviews as well as expedited internal and external reviews based on medical necessity. The Company does not have a written file documentation or file retrieval process,

The examiners reviewed a sample of fifty (50) Grievance files. The examiners observed that pertinent documentation was missing from thirty nine (39) or seventy eight percent (78%) of the reviewed files as they were originally provided to the examiners. The missing documentation included claim forms related to the grievance as well as copies of policy provisions. Reviewed files also lacked Explanations of Benefits (EOB), correspondence, and documentation related to the final resolution of the grievance. Additionally, date stamps were missing in fifteen (15) or thirty percent (30%) of the files. Rescissions were the subject of six (6) or twelve percent (12%) of the grievances.

Grievance Number G-3

One grievance was submitted from an insured who asserted that her policy was improperly rescinded. The examiners found that, the Company failed to comply with a mandatory provision included in the insurance contract. The provision entitled "Time Limits on Certain Defenses" was the basis of the Company's rescission of the policy in file number G-3. The examiners contended in a memo to the Company that they should not have rescinded the policy because it had been in-force for more than three years and there was no evidence presented by the Company of fraudulent intent on the part of the insured in the statements made in the application for the policy.

In the Company's response to the examiners memo (13a dated 12/17/2008) the Company upheld their decision to rescind the insured's policy. However, the examiners believe that the Company's argument is without merit. The Company, in their response, appears to attribute the same meaning to the word "fraudulent" as it does to "incorrect" or "inaccurate" as it relates to the applicant's statements in the question relating to her use of prostheses.

The language in the question on the original application appears to be subject to interpretation as its meaning was not clear to the insured or the selling agent. The insured may have made an inaccurate response but it did not appear to have been fraudulent. For their part, the Company did not assert that the insured had fraudulent intent.

The grievance file documents contain the statement of the insured asserting that the application question referred only to "fixed Prostheses." Question C-2 states (Does any applicant) "Had/Have any fixation/prosthetic devices including, but not limited to, plates, screws, pins, implants (including breast implants), shunts, pacemakers or valve replacements?" The insured stated that she did not believe that the question pertained to the foot prostheses she wore to correct a congenital deformation. A letter from the agent who sold the policy supported the insured. They both stated that they understood that prostheses mentioned in the question referred to internal or fixed items.

The intent of the 'Time Limits' provision (also known as the incontestable provision) is, in the examiners' interpretation, to place a reasonable time limit during which inaccurate statements or omissions may be challenged by the insurer. In this instance, the limit of two years had passed. The policy was in-force for three years and one hundred fifty two days. After this span of time the 'Time Limits' provision is intended to protect the insured from cancellation by the insurer for all causes except if the insurer can establish fraudulent intent on the part of the insured.

The Company demanded in their rescission letter that the insured repay $14,000 in past claim payments. The Company went on in their letter to offer a 'break' of sorts. If the insured signed the settlement form cancelling her policy in the time allotted, they would forgive the debt that they implied she had accumulated. The insured capitulated and signed the document.

The examiners reviewed two grievance files where the Company's acknowledgement of the grievances contained an incorrect citation of the Michigan Code. ACT, MI ACT 571. The citation provides the insured inaccurate information regarding their rights and the Company's responsibilities associated with grievances. The Company acknowledged their error and has modified its template letter to reference the MI ACT 251.

The grievance file reviews indicated a possible statewide issue regarding denied claims and Emergency Room (ER) services. In the reviewed sample, ten (10) grievances or twenty percent (20%) of the sample population were related to emergency room claims that were initially denied by the Company who stated that these claims did not represent emergencies. Following the consumers' complaints the Company resolved the grievances in favor of the claimant, all of the claim denials were overturned and paid by the Company. The examiners' review of the sampled grievances indicate a possible systemic issue of improper claim settlement practices related to ER claims for illnesses during the examination period. The Company was asked to provide the examiners a listing of all denied ER claims in 2007 that met these criteria. The Company subsequently provided a listing of eight hundred four (804) denied ER claims from 2007. This appears to be a violation of Michigan statute MCLS§ 500.2026(f) failure to settle claims when liability is reasonably clear.

Recommendations: It is recommended that the Company reinstate the rescinded policy that was the subject of the G-3 grievance (policy no. 2044756) reviewed in this report. It is further recommended that the Company formulate, adopt and implement a written procedure for documentation standards to ensure accurate and complete grievance files. The examiners further recommend the establishment of date stamping standards relating to all grievance

correspondence. It is also recommended that the Company institute a template documentation review procedure to ensure accurate citations of statutes and regulations. Please also refer to claims section for recommendations relating to the adjudication of ER claims.

Complaints

Standard 3

The Company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language.

Observations: The examiners reviewed 24 complaint files recorded during the examination period. Nineteen (19) or seventy-nine percent (79%) of the complaint files were related to individual health policies. The examiners found that these nineteen (19) individual insurance sampled files lacked adequate documentation. The examiners were unable to determine if complaints were properly resolved until the Company provided additional documentation to complete the file. Additionally, eleven (11) files or forty five percent (45%) of complaints were not date stamped to indicate when they were received. The examiners also found that in two complaint files, the Company did not adequately address all issues brought forth in the complaint. Both instances related to alleged agent misrepresentations.

Recommendation: It is recommended that the Company formalize complaint handling procedures to ensure accurate and complete complaint responses.

Claims

Standard 3

Claims are resolved in a timely manner.

Observations: The Company does have a written procedure for resolving claims in a timely manner. These procedure steps require the claims examiners to refer to state specific areas where applicable. In these cases, the Company stated that they use the strictest Regulation or Law enacted among the states where they do business. Michigan law requires clean claims to be settled within forty-five (45) days. Michigan statute MCLS§ 500.2006 (8)(a) states "A clean claim shall be paid within 45 days after receipt of the claim by the health plan. A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum." The examiners' time study found that forty-nine (49) or ninety-eight percent (98%) of the paid claims and fifty (50) or one hundred percent (100%) of denied claims were settled in a timely manner.

The examiners found, ten (10) grievances that were related to emergency room claims that were initially denied by the Company who stated that these claims did not represent emergencies. Following the consumers' complaints the Company resolved the grievances in favor of the claimant, all of the claim denials were overturned and paid by the Company. The examiners' review of the sampled grievances indicate a possible systemic issue of improper claim settlement

practices related to ER claims for illnesses during the examination period. The Company was asked to provide the examiners a listing of all denied ER claims in 2007 that met these criteria. The Company subsequently provided a listing of eight hundred four (804) denied ER claims from 2007. This appears to be a violation of Michigan statute MCLS§ 500.2026(f) failure to settle claims when liability is reasonably clear. Please see also examiners' comments in complaint section of the report.

Recommendation: It is recommended that the Company address improper claim settlement practices related to ER claims for illnesses during the examination period. Michigan statute MCLS§ 500.2026(f) prohibits insurers' failure to settle claims when liability is reasonably clear. The Company shall provide a listing of denied ER claims for calendar years 2005 through 2008 to OFIR. The Company shall review and evaluate each claim listed to determine if additional payment is necessary and shall report the results to the OFIR. In addition, the Company shall ensure, prospectively they are processing ER claims correctly.

Underwriting and Rating
(Examiners' note; this portion of the review was limited to the review of rescinded policy activity.)
Standard 6a

Determine if rescinded policies indicate a trend toward post claim underwriting practices.

Observations: Policy rescissions were found only among individual plans issued by the Company. The Company reported that they issued 9571 total individual plans of health insurance in Michigan during the examination period. The most frequently sold policies are the short term plans offering coverage for terms of one to six months. Sales of short term plans account for 3282 policies or thirty four percent (34%) of individual sales. Only seven short term plans were rescinded in 2007. Short term plans are not subject to the thorough underwriting procedures applied to long term coverage plans and pre-existing conditions are not covered.

The most popular permanent individual plan sold by ACMIC is the "Community Preferred" plan (Code PPOD). There were 2810 of these plans issued in Michigan in 2007 or twenty nine percent (29%). One hundred sixty eight (168) or six percent (6%) of these plans were rescinded in 2007.

Applications for permanent and short term, individual policies are submitted to the Company by appointed agents, identified by the Company as independent agents or brokers. These agents work through a system of the Company's General Agents (GA) located throughout the state. The Company reported that there were 2793 agents appointed by the Company in the state of Michigan during the examination period.

One hundred ninety-seven (197) individual health policies of all types were rescinded, or cancelled as of their effective date, by the Company in 2007. The examiners' analyzed the total population of rescissions and found that thirty- seven (37) agents sold two or more policies that were subsequently rescinded. One hundred twenty two (122) or sixty two percent (62%) of the rescinded policies were sold by these agents. One agent, who is also listed as a GA, was

responsible for 11 rescissions from personal sales. This GA and one sub-agent accounted for a total of twenty (20) rescissions in 2007. Another one of the Company's GA who supervised twelve sub-agents was associated with a total of forty three (43) rescinded policies. Together, these two GAs were associated with thirty two (32%) of all of the Company's Michigan rescissions.

The examiners also found that twelve percent (12%) of total grievances submitted to the Company were related to the Company's decision to rescind a health insurance plan. The examiners requested a sample of complaint and rescission files to discern patterns of sales practices that may have contributed to these terminations and if the Company was aware of these factors. In order to provide the selected files, the staff members assembled documents from five separate company systems. The examiners found that the Company did not maintain rescission files in an organized fashion. Because of this, the examiners suggest that it would have been difficult for the Company to identify the relationship between agent sales activities, grievances and rescissions.

The Company does not maintain written documentation standards or procedures for rescission files. One result of the observed lack of standards was evident when the Company provided the rescission files without copies of the original applications, although these documents are referenced in each rescission file. The Company stated also that they had no on-going procedure to assess complaints/grievances received by the Company in order to discern potentially improper marketing practices. The Company stated, however, that they have performed targeted internal audits of complaints/grievances in the past but there were none conducted in 2007.

In order to complete the sale of a Company health policy, the agent is instructed to facilitate the completion of the application form. For permanent plans, this application requires the applicant to provide complete details in answer to one hundred thirty three (133) separate health status related questions for the primary applicant as well as dependants. This health history is required to cover a period of ten (10) years prior to the date of application. The examiners found that many of the applications were submitted with no medical history. The examiners note that the Company's acceptance of health applications for processing without medical history is an unsuitable practice. The examiners also find that it is not reasonable for such a large percentage of applicants of any age to have had no medical conditions, treatment or diagnoses beyond a 'regular checkup' during a ten year period especially where the questions involve significant detail.

The examiners reviewed a sample of fifty (50) rescinded policy files from a population of one hundred ninety seven (197) cancelled individual policies. All of the policies rescinded in the sample were within two years of the issue date with an average of two hundred sixty five (265) days in-force.

The examiners found that in twenty three (23) or forty six percent (46%) of the reviewed files, the application was submitted, processed by the Company and a policy issued where all but the question, related to regular checkups, was answered 'NO'. In the remaining twenty seven (27) files, the applicants admitted to various diagnoses, conditions or treatments. The average time elapsed between the receipt of the application at the Home Office and the issuance of a policy was only 10.9 days.

The examiners found that in one hundred percent (100%) of the reviewed files, the Company failed to request medical records, Attending Physician Statements (APS) and background questionnaires or any other active underwriting actions prior to issue of the policies under review. This information was noted in the Post Issue Worksheets provided with each file.

In addition to the observed absence of pre-issue underwriting action, the examiners found substantial evidence of post claim underwriting activity. Among the methods used by the Company to closely monitor early claim activity are the referrals to the PE (pre-existing claim) team and the PI (post-issue) team. Claims submitted to the Company from the effective date out to twenty four (24) months are screened by the Post Issue program. The "ICD-9 Codes for Post Issue Review" is a spreadsheet document provided to the examiners. The claims screening intercepts claims that relate to over 1000 ICD-9 diagnostic codes listed in the spreadsheet. The claims, identified by the screening, are first referred to the PE team and then, if claims represent significant issues, to the PI team. The PI team requires the claimant to complete and sign a questionnaire, known as the A-20 form. The form requires the claimant to provide contact information for all physicians and providers of service to the Company. The form contains an authorization to request medical records. All claim payments are suspended until this form is returned. The PI team produces an extensive file prior to a decision by the Company to cancel the policy from inception and return the insured's premiums less claims paid. Unlike the issuance of new policies, the PI files average ninety five (95) pages in length. In the reviewed files, the examiners found that the claims triggering the PE and PI review average sixty one (61) days from the policy's effective date.

All reviewed files showed that rescission decisions were made as the result of the failure of the applicant to provide accurate answers to the health related questions on the application and/or the failure of the applicant to provide sufficient details regarding pre-existing conditions. The examiners did not dispute the findings of fact by the Company in any of their decisions to terminate a policy.

Despite the lack of pre-issue underwriting, the Post Issue team was exceptionally thorough in their documentation to support their case for rescission. Most rescission letters list four to ten questions that the Company claims were answered incorrectly or incompletely. The Company backed all of their allegations with substantial documentation. The reviewed files contained copies of refund of premium checks or documentation to support that no refund was due.

Standard 6b

Determine if decisions to rescind policies are made in accordance with applicable statutes rules and regulations.

Observations: The examiners found that individual reasons underlying the basis to rescind policies were not in violation of applicable Michigan statutes, rules and regulations. However, the examiners found that activities at the Company involved in the sale of new individual policies represented unfair marketing practices.

Individual policies issued by the Company were not subjected to underwriting standards that would reasonably provide the Company with an accurate assessment of an applicant's

qualification for issuance of a health insurance policy. Individual policies were issued without proper scrutiny and premiums collected only to be subjected to a rigorous post-claim underwriting process. Policies were subsequently rescinded based on information that would have been available to the Company in the course of a regular pre-issue underwriting process.

Customers were subjected to claim denials by the Company which could have been avoided if the Company had subjected these applications to a predictive underwriting process. Additionally, the Company knew, or should have known, that a small number of their appointed agents were responsible for regularly submitting applications with little or no medical information and that these policies were often the subject of later rescission. These findings represent unfair trade practices as defined in MCL § 500.2002 and may be subject to regulatory action under provisions of MCL § 500. 2043.

Recommendation: It is recommended that the Company implement an adequate process for pre-issue underwriting. The purpose of this underwriting activity shall be to minimize post-claim rescissions and unfair trade practice violations.

ACKNOWLEDGMENT

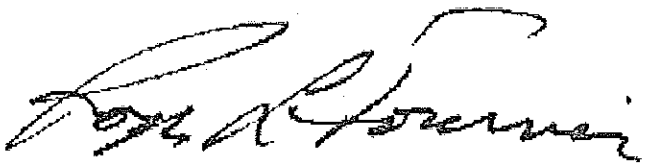
This is to certify that the undersigned is duly qualified and, in conjunction with INS Regulatory Insurance Services, Inc., applied certain agreed-upon procedures to the corporate records in order for the OFIR to conduct a target scope market conduct examination of the Company.

The undersigned's participation in this target examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination which was performed in accordance with, and substantially complied with those standards established by the National Association of Insurance Commissioners (NAIC) and the *NAIC Market Regulation Handbook.* This participation consisted of involvement in the planning (development and supervision), administration and preparation of the limited scope examination report.

The cooperation and assistance the officers and employees of the Company extended to all examiners during the course of the examination is hereby acknowledged.

CONCLUSION

The market conduct examination was conducted at the direction of, and under the overall management and control of Regan Johnson of the OFIR. The examination activities were conducted by Roger L. Fournier, CIE, AIRC, MCM; Parker WB Stevens, CIE, MCM; Sean Connolly, AIE; MCM and was supervised by Shelly G. Schuman, ACS, AIE, FLMI, HIA, MCM. The examination Report is respectfully submitted.



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