

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Invitees to September 1, 1998 Meeting with Chris Jennings; Social Security numbers redacted (1 page)	nd	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23756 Box 8

FOLDER TITLE:

Fighting Republicans on Coverage [3]

gf17

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MSA Pilot

Control Number: OGI-112982-97

Part IV. Items of General Interest

Medical Savings Accounts

Announcement 97-79

PURPOSE

Sections 220(i) and (j) of the Internal Revenue Code provide that if the number of medical savings accounts (MSAs) established as of April 30, 1997, exceeds 375,000, then September 1, 1997, is a "cut-off" date for the MSA pilot project. The Internal Revenue Service has determined that the applicable number of MSAs, established as of April 30, 1997, is 7,383. Consequently, September 1, 1997 is not a "cut-off" date for the MSA pilot project. A second determination of whether 1997 will be a cut-off year, based on whether the number of MSAs established as of June 30, 1997 exceeds 525,000, will be made by October 1, 1997. See section 220(j)(1)(B) of the Code.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 added section 220 to the Code to permit eligible individuals to establish MSAs under a pilot project effective January 1, 1997. The pilot project has a scheduled "cut-off" year of 2000, but may have an earlier "cut-off" year if the number of individuals who have established MSAs exceeds certain numerical limitations. See sections 220(i) and (j).

If a year is a "cut-off" year, section 220(i)(1) generally provides that no individual will be eligible for a deduction or exclusion for MSA contributions for any taxable year beginning after the cut-off year unless the individual (A) was an active MSA participant for any taxable year ending on or before the close of the cut-off year, or (B) first became an active MSA participant for a taxable year ending after the cut-off year by reason of coverage under a high deductible health plan of an MSA-participating employer.

Section 220(j)(1) provides that the numerical limitation for 1997 is exceeded if the number of MSAs established as of April 30, 1997, is more than 375,000, or if the number of MSAs established as of June 30, 1997, is more than 525,000. Under section 220(j)(3), in determining whether any calendar year is a cut-off year, the MSA of any previously uninsured individual is not taken into account. In addition, section 220(j)(4)(D) specifies that, to the extent practical, all MSAs established by an individual are aggregated and two married individuals opening separate MSAs are to be treated as having a single MSA for purposes of determining the number of MSAs.

Based on Forms 8851 provided by MSA trustees and custodians, it has been determined that 9,720 taxpayers have established MSAs as of April 30, 1997. Of this total, 1,787 taxpayers were reported as previously uninsured, and are therefore not taken into account in determining whether 1997 is a cut-off year. In addition, 550 taxpayers were reported as excludable from the

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count because their spouse also established an MSA. Accordingly, because the applicable number of MSAs established as of April 30, 1997, 7,383 (9,720 minus (1,787 plus 550)) is less than 375,000, 1997 is not a cut-off year for the MSA pilot project. The service intends to publish another announcement, not later than October 1, 1997, concerning whether 1997 is a cut-off year based on the number of MSAs established as of June 30, 1997.

Questions regarding this announcement may be directed to Felix Zech in the Office of Associate Chief Counsel (Employee Benefits and Exempt Organizations) at (202) 622-4606 (not a toll free number).

HUG 31 36 23-25TH CONSUMER UNION - DC P. 21

Health Mart File

May 28, 1998

Dear Representative:

As representatives of consumers, seniors, health care and religious providers, people with disabilities and chronic illnesses, and working families, we are writing to urge you to either drop consideration of the HealthMarts proposal from the health care bill, or modify it so that it meets the needs of consumers. As outlined in a draft proposal by Congressman Hastert's task force, HealthMarts are non-profit health coverage purchasing pools designed to make health coverage options available, at group rates, to members, similar to the health alliances included in the Clinton health plan. We support efforts to make health care more affordable while maintaining quality and access to care. However, there are serious problems with the new draft proposal that undermine those goals. As presently drafted, HealthMarts hold the potential to turn the clock back on the goal of providing more Americans with quality, affordable health care coverage. Our key concerns are:

- **Selection:** Only companies (and the self-employed) that lack better insurance alternatives will be attracted to HealthMarts, meaning a relatively high-risk (and high-cost) pool, and calling into question HealthMarts' ability to provide low-cost coverage. This may, in fact, have the effect of disrupting recent state activities to achieve benefits of pooling for all small businesses or individuals through community rating and rating bands. Within HealthMarts, the choices presented to consumers (ranging from skimpy to comprehensive) may also result in selection problems, encouraging the healthy to enroll in barebones plans and assuring high premiums for people desiring comprehensive plans. Plans should have to comply with state rating laws in order to reduce this disruption.
- **Individual market:** The most serious obstacles to obtaining affordable coverage are found in the individual market. However, this proposal does not address the needs of individuals and their families (including those whose employers do not offer coverage), since they are not eligible for HealthMarts. Individuals and their families should have access to HealthMarts.
- **State mandates:** A key tool used to attempt "affordability" is waiving of state benefit mandates. States have mandated benefits such as maternity coverage, cancer screening, mental health services, and coverage for birth defects for legitimate policy reasons. Allowing barebones coverage means consumers' needs will not be met and costs will be shifted to individuals and families who need those services. HealthMarts should meet minimum benefit requirements,

achieving savings through pooling and bargaining power not by shifting costs to consumers.

- ***Impact on state alliances:*** Many states have already established health alliances, and their continued development could be in jeopardy if new voluntary HealthMarts (with barebones coverage) are introduced and draw relatively healthy enrollees. HealthMarts should be established in conjunction with state alliance laws.
- ***Affordability:*** The bill does not provide targeted subsidies to the working poor, those most in need of help in paying for health insurance coverage.
- ***Risk sharing:*** Some states have taken steps to assure that health insurance is affordable to people with high risks. HealthMarts may undermine efforts to address that problem by attracting healthier individuals and segmenting the market.
- ***Inadequate benefit package:*** We believe that the key to expanding affordable coverage is the development of comprehensive, standard, quality coverage. HealthMarts move coverage in the opposite direction by preempting state laws without substituting a basic benefits package in their place.
- ***Medical savings accounts:*** This proposal lists medical savings accounts as an option for coverage in HealthMarts, undermining the intent of Congress in the Health Insurance Portability and Accountability Act of 1996 to try medical savings accounts on a trial basis only. This option should be eliminated from the bill.
- ***Conflict-of-Interest on the Board:*** The proposal calls for representatives of insurance companies, health maintenance organizations, and providers to serve on HealthMarts' board of directors. For HealthMarts to be responsive to consumers' needs and to be able to negotiate effectively, boards should consist primarily of consumers but should not include insurance company representatives.
- ***State and federal consumers protections:*** The proposal creates a potential loophole to the ability of states and the federal government to enforce their consumer protection regulations, by allowing nationally recognized accrediting body to accredit carriers "as meeting such requirements or comparable standards." This provision should be eliminated, and it should be made clear that states and the federal government can enforce their standards.

We strongly oppose the HealthMarts proposal as presently drafted, and urge you to drop it from consideration this year.

Sincerely,

AIDS Action
American Association on Mental Retardation
American Counseling Association
American Federation of State, County and Municipal Employees
American Nurses Association
American Public Health Association
The ARC of the United
Bazelon Center for Mental Health Law
Brain Injury Association
Center for Women Policy Studies
Center on Disability & Health
Children's Defense Fund
Church Women United
Committee for Children
Communication Workers of America
Consumer Coalition for Quality Health Care
Consumer Federation of America
Consumers Union
Council of Jewish Federations
Eldercare America, Inc.
Families USA
Gay Men's Health Crisis
Gray Panthers
Health Care for the Homeless
Human Rights Campaign
National Association of Developmental Disabilities Councils
National Association of People with AIDS
National Association of Protection and Advocacy Services
National Association of Psychiatric Treatment Centers for Children
National Association of Social Workers
National Association of State Directors of Special Education
National Black Women's Health Project
National Caucus and Center on Black Aged, Inc.
National Citizens Coalition for Nursing Home Reform
National Consumers League
National Council for Community Behavioral Health Care
National Council of Senior Citizens
National Education Association

National Farmers Union
National Gay and Lesbian Task Force
National Health Law Program
National Hispanic Council on Aging
National Mental Health Association
National Minority AIDS Council
National Multiple Sclerosis Society
National Osteoporosis Foundation
National Parent Network on Disabilities
National Puerto Rican Coalition
National Senior Citizens Law Center
National Women's Health Network
Neighbor To Neighbor
Network: A National Catholic Social Justice Lobby
Older Women's League
Service Employees International Union
Summit Health Coalition
United Cerebral Palsy Associations, Inc.
Universal Health Care Action Network

Withdrawal/Redaction Marker

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For a complete list of items withdrawn from this folder, see the
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**Invitees for September 1, 1998
Meeting with Chris Jennings at 3:00
OEOB Room 180**

Gail Shearer

P6/b(6)

Consumers Union

Adrienne Mitchem

P6/b(6)

Consumers Union

Maria Fiordellisi

P6/b(6)

AFL-CIO

Cathy Hurwit

P6/b(6)

**American Federation of State, County, and
Municipal Employees**

Joan Alker

P6/b(6)

Families USA

Lisa Cox

P6/b(6)

National Women's Health Network

Alfonso Guida

P6/b(6)

National Mental Health Association

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PHOTOCOPY**

Douglas Stone

P6/b(6)



National Council of Senior Citizens

Kammie Monarch

P6/b(6)



American Nurses Association

Kathy McGinley

P6/b(6)



The ARC

Vicki Gottlich

P6/b(6)



National Senior Citizens Law Center

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PHOTOCOPY**

FILE MEWAs FROM: Jeff Ricchetti, PSW
783-2596
628-5379 (FX)

Consensus Group Conference Recommendations

MEWAs

Provision	House - Education and Workforce	Senate	Consensus Group Recommendation
MEWAs/Association Health Plans (AHPs)	<p>Amends ERISA to permit associations, franchise networks, multiple employer welfare arrangements (MEWAs) and certain other entities to apply for federal certification as association health plans (AHPs).</p> <p>Certified AHPs are generally exempt from state regulation, similar to other ERISA plans.</p> <p>State benefit standards and rate regulation would be preempted with regard to health coverage offered in connection with an AHP.</p> <p>AHP health plans must meet sponsorship, participation, contribution, and solvency standards that are generally less stringent than those required at the state level.</p>	None.	Oppose inclusion of any MEWA/AHP exemption.

The Consensus group is comprised of Blue Cross and Blue Shield Association (BCBSA), the American Association of Health Plans (AAHP), and the Health Insurance Association of America (HIAA).

The Consensus group recommendation's are subject to revision pending receipt of final Senate Finance Committee legislative language which was not available at this time.

BCBSA Language Comments on PSOs

Assuring Compliance with State Non-Financial Laws

Recommendation:

(A) TREATMENT OF WAIVER -- In the case of a waiver granted to a provider-sponsored organization --

"(i) the waiver shall be effective until such time as the state adopts the federal financial standards approved by the Secretary on January 1, 2001, whichever occurs earlier, and

"(ii) any provisions of state law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded. The preceding sentence shall not be construed as superseding any non-solvency State law or regulation, including those related to licensure, that are applied on a uniform basis and are generally applicable to other entities engaged in substantially similar business, and that are in addition to, or more stringent than, those provided under the standards under this subsection.

(B) ENFORCEMENT OF CERTAIN STATE LAWS, --

"(i) State requests for information.--A provider sponsored organization that has received a waiver under this paragraph shall comply with State requests for information relating to the organization's compliance with the laws described in the last sentence above in each State in which the organization operates. The State shall promptly report to the Secretary any organization that has failed to comply with the applicable laws.

"(ii) Fees.--A state that requests information under clause (i) may assess a reasonable fee established by the State from each provider sponsored organization that has received a waiver under this paragraph and that is operating in the State in order to reimburse the State for collection and processing of the compliance information.

"(iii) Certification.--Each provider sponsored organization that has received a waiver under this paragraph shall annually certify to the Secretary and to the State Insurance Commissioner that it is in compliance with the laws specified above in each State in which the organization operates.

"(iv) Termination of waiver.--The Secretary shall notify the PSO that the PSO must be in compliance within sixty days. If the PSO fails to comply, the Secretary may (1) terminate the waiver of any provider sponsored organization that has been reported by the State as being out of compliance with the laws

Attachment 1

described in the last sentence of the above subparagraph, or (II) assess civil money penalties.

"(v) **Substantially similar business.**--For purposes of this paragraph, the term "substantially similar business" includes but is not limited to the Medicare business of licensed risk bearing entities such as health maintenance organizations.

BCBSA Language Comments on PSOs

Effective Date: No waiver shall be granted under this subsection until the date of publication of regulations by the Secretary regarding financial standards for Provider Sponsored Organizations.

Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
RETENTION OF STATE OVERSIGHT OF PSOs THROUGH LIMITATION ON 'TRIGGERS' AND WAIVERS				
Waiver Terminates Once State Has Solvency Standards Identical to Federal Standards	No provision.	No provision.	Federal waiver is effective until the state in which the PSO is located receives federal certification that the state's solvency requirements for PSOs are identical to federal standards.	Support Finance.
Waiver Conditioned Upon Requirement That PSO Has Filed For A License With The State	<u>Sec. 1855 (a)(2) (E)(ii):</u> Waiver is conditioned upon pendency of licensure application.	No provision.	No provision.	Support Commerce.
90 Day Trigger of Federal Waiver Process	<u>Sec. 1855 (a)(2)(B):</u> Federal waiver triggered if state has failed to complete action on a licensing application of the PSO within 90 days of the date of the state's receipt of the application.	<u>Sec. 1855 (a)(2)(B):</u> Federal waiver triggered if state has failed to complete action on a licensing application of the PSO within 90 days of the date of the state's receipt of the <u>completed</u> application.	No provision.	Support Finance approach, but if 90 days is included as a 'trigger', adopt Ways & Means version which specifies that it must be a <u>completed</u> application that initiates the 90 day period. ¹

¹ AAHP supports the requirement that PSOs may not seek a federal waiver until the expiration of the 90 day period.

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Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
Start of 90 Day Trigger Based on Promulgation of Standards	<u>Sec. 1855 (a)(2)(B):</u> No period before the date of the enactment shall be included in determining the 90 day period.	Same as Commerce.	No provision.	Support Finance approach which excludes 90 day trigger altogether. However, if 90 day trigger adopted, the start of the 90 days should be based on promulgation of standards, rather than on enactment.
Different State Documentation Standards Related to Solvency Trigger Federal Waiver	<u>Sec. 1855 (a)(2)(D)(ii):</u> Federal waiver triggered if state documentation or information requirements relating to solvency differ from those applied by the Secretary.	Same as Commerce.	No provision.	Support Finance. This is not a legitimate 'trigger' for a federal waiver -- (e.g., under this provision, the 'trigger' to a federal waiver could be the result of the state simply using a different accounting form).
APPLICATION OF STATE NON-FINANCIAL HEALTH PLAN STANDARDS				
State Non-Financial Laws Apply to PSOs	<u>Sec. 1855 (a)(2)(E):</u> There will not be a waiver of any provision of State law which relates to quality of care or consumer protection (and does not relate to solvency standards) and which is imposed on a	No provision.	PSOs receiving a federal waiver will be required to comply with all other (non-solvency) State requirements, including the state's consumer protection standards. The state will report to the Secretary any	Support Commerce/Finance with enforcement clarified. (See Attachment #1)

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JUN 23 '97 03:32PM BCBSA OGR

Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
	uniform basis and is generally applicable to other entities engaged in substantially similar business.		organization that has failed to comply with the applicable laws. If the Secretary determines that the PSO is not in compliance with state requirements, the Secretary will terminate the waiver or assess a civil penalty.	
Preemption of State Laws Inconsistent with Medicare Law	<p>Sec. 1856 (b)(5): Subject to section 1852(n), federal standards supersede any State law or regulation, with respect to MedicarePlus plans to the extent such law or regulation is <u>inconsistent</u> with such standards. However, this shall not be construed as superseding a State law or regulation that is not related to solvency, that is applied on a uniform basis and is generally applicable to other entities engaged in substantially similar business, and that provides consumer protections in addition to, or more stringent than, those provided under the standards under this subsection.</p>	<p>Sec. 1856 (b)(5): Federal standards supersede any State law or regulation with respect to MedicarePlus plans to the extent such law or regulation is <u>inconsistent</u> with such standards.</p>	No provision.	Support Commerce.

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Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
'Substantially Similar' Definition	No provision.	No provision.	No provision.	Add to legislative language -- <i>'Substantially Similar Business' includes, but is not limited to, the Medicare business of licensed risk bearing entities such as health maintenance organizations.</i>
Benefits and Beneficiary Protections	<u>Sec. 1852 (m)</u> Allows States to establish or enforce requirements with respect to beneficiary protections, but only if such requirements are more stringent than the federal requirements.	No provision.	No provision.	Support Ways & Means/Finance. This provision is redundant.
EFFECTIVE DATES AND TIMING ISSUES				
Sunset of Federal Waiver Process	No provision.	No provision.	Federal waiver sunsets January 1, 2001.	Support Finance.

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Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
Effective Date of Federal Certification Process	None specified.	None specified.	None specified.	Link effective date to promulgation of standards. (See Attachment #2)
Target Date for Publication of Rule.	<u>Sec. 1856 (a)(3).</u> The 'target date for publication' of the rule shall be April 1, 1998.	Same as Commerce.	No provision.	Support Commerce/Ways & Means.
DEFINITION OF PSO				
'Locally Organized and Operated' and Inclusion of 'Majority Financial Interest'	<u>Sec. 1855 (e)(1).</u> A provider-sponsored organization is a public or private entity (A) that is established or organized by a health care provider, or group of affiliated health care providers, (B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and (C) with respect to which those affiliated providers that	Same as Commerce.	A PSO is defined as a <u>locally organized and operated entity</u> that provides a substantial portion of services directly through affiliated providers, and that is organized to deliver a spectrum of health care services.	Support Finance, plus add Commerce/Ways & Means paragraph (C): <i>with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.</i>

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Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
	share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.			
Definition of 'Affiliated' Provider(s)	<p>Sec. 1855 (e)(3). A provider is affiliated with another provider if, through contract, ownership, or otherwise</p> <p>(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,</p> <p>(B) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or</p> <p>(C) both providers are part of an affiliated service group under section 414 of such Code.</p>	Same as Commerce.	A provider is affiliated if through contract, ownership or otherwise (1) one provider, directly or indirectly, is controlled by, or is under common control with the other (2) both providers are part of a controlled group of corporations (3) each provider is a participant in a lawful combination under which the providers share substantial financial risk in connection with the PSO's operations or (4) both providers are part of an affiliated service group.	Support Commerce/Ways & Means. The Finance amendment by Rockefeller would allow loosely affiliated providers with no ownership in a PSO to be considered an 'affiliated' provider.
SOLVENCY AND INSOLVENCY STANDARDS				

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Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
Solvency Standards for all Medicare Plans	No provision.	No provision.	Eligible Medicare Choice plan sponsoring organizations must meet solvency requirements satisfactory to the Secretary of HHS. Organizations licensed in states recognized by the Secretary of HHS as requiring solvency standards at least as stringent as those required by Medicare will be deemed to meet Medicare Choice plan solvency requirements.	Support Commerce/Ways & Means. Or, if Finance language included, clarify that the language should not be construed to imply that a state must change solvency standards for Medicare Choice Plans other than PSOs.
Factors to Consider When Developing Solvency Standards	Sec. 1856 (a)(1)(B) In establishing solvency standards for PSOs, the Secretary shall consult with interested parties and shall take into account (i) the delivery assets of such an organization and ability of such an organization to provider services directly to enrollees through affiliated providers, and (ii) alternative means of protecting against	Same as Commerce.	Secretary is instructed to consider the NAIC's risk-based capital standards as part of negotiated rule-making process.	Support Finance. Also support insolvency standards (e.g., hold harmless provision) described in all three bills.

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Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
	insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care.			
OTHER PREFERENTIAL STANDARDS FOR PSOs				
Minimum Enrollment	<u>Sec. 1857 (b).</u> Reduces minimum enrollment requirements for PSOs to 1,500 (500 in rural areas). The Secretary may waive the requirement during the first 3 contract years with respect to an organization.	Same as Commerce.	A Medicare Choice organization must have a minimum of 1,500 commercial enrollees, or not less than 500 commercial enrollees in rural areas. PSOs can include as commercial enrollees those individuals for whom the organization has assumed financial risk. This requirement will be waived for the first 2 years of a Medicare Choice contract.	Oppose all versions. Support continuation of current law for all Medicare risk plans.

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Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
Assumption of Full Financial Risk	<p><u>Sec. 1855 (c).</u> The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, hospice care) for which benefits are required to be provided under section 1852 (a)(1), except that the organization</p> <p>(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds \$5,000 in any year,</p> <p>(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,</p> <p>(3) may obtain insurance or make other arrangements for</p>	Same as Commerce.	All Medicare Choice plans must assume full financial risk on a prospective basis for the provision of health care services, except the organization may insure or make arrangements for stop-loss coverage for costs exceeding an amount established by regulation and adjusted annually based on the CPI; services provided to members by providers outside of the organization; and for not more than 90 percent of costs which exceed 115 percent of income in a fiscal year. An organization may also make arrangements with providers to assume all or part of the risk on a prospective basis for the provision of basic health services.	Support Finance because Finance indexes thresholds to CPI.

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JUN 23 '97 03:35PM BCBSA OGR

Consensus Group Conference Recommendations

Provider Sponsored Organizations

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
	<p>not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and</p> <p>(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.</p>			

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Consensus Group Conference Recommendations

PSOs: Technical Corrections

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
Exemption for Licensure if State Requires Another Product to be Offered Other Than a MedicarePlus Plan.	<u>Sec. 1855(a)(3).</u> Exception if Required to Offer More than MedicarePlus Plan. Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus Plan.	Same as Commerce.	No provision.	Support Finance. If Commerce/Ways & Means adopted, then clarify that the exception is applicable only as long as the eligible organization is solely offering a MedicarePlus plan.
State Laws Related to Licensing Superseded	<u>Sec. 1855(a)(2)(E)(iii)</u> Any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.	Same as Commerce.	No provision.	Add sentence to end of Commerce/Ways & Means language as follows: <i>The previous sentence shall not be construed to exempt any state law related to licensure that relates to the non-Medicare business of a PSO.</i>
Secretary Must Act Within 60 Days of Completed Application.	<u>Sec. 1855 (a)(2)(F).</u> The Secretary shall grant or deny such a waiver application within 60 days	Same as Commerce.	No provision.	Clarify that all types of Medicare Risk plans are treated equitably. Concern here is that with

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Consensus Group Conference Recommendations

PSOs: Technical Corrections

Provision	House Commerce MedicarePlus	House Ways & Means MedicarePlus	Senate Finance (Outline) Medicare Choice	Consensus Group Recommendations
	after the date the Secretary determines that a substantially complete application has been filed.			short deadline for PSO applications, other risk plans' applications will be delayed.
Adjusted Community Rate: Special Rule for PSOs	<u>Sec. 1854 (f)(4)(B).</u> This provision gives MedicarePlus PSOs a special way to establish their ACR using data in the general commercial marketplace or (during a transition period) based on costs incurred by the organization in providing such a plan.	Same as Commerce.	Same as Commerce.	Since some PSOs are in the commercial business, it should be clarified that this provision only applies to PSOs that have only Medicare business.

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JUN 23 '97 03:37PM BCBSA OGR

Consensus Group Conference Recommendations

Managed Care Payment

Provision	Commerce-- MedicarePlus	W&M--Medicare Plus	Finance--Medicare Choices	Consensus Group Recommendation
GME/DSH Carveout	<u>1853(c)(3)(B) [p.42]</u> Phases out GME and DSH payments from the local part of the payment, 20% a year until they are gone in 2002	<u>No Provision</u>	Remove GME and DSH payments from the local part of blend over 4 years.	Support W&M retention of GME/DSH.
Reduced Payment for New Enrollees	<u>No Provision</u>	<u>No Provision</u>	Until such time that the Secretary has a better risk adjuster, new enrollees will be paid at 5% less for 1st year, 4% for 2nd, 3% for 3rd, 2% for 4th, and 1% for 5th, with a 1-year delay for new plans (most likely in low-payment areas).	Oppose Finance and support continuation of current policies as in Commerce and W&M.
National Inflation Update	<u>1853(c)(6)(A)-(B) [p.46]</u>	<u>1853(c)(6)(A)-(B)</u> Secretary's projected	Per capita GDP	Support W&M and

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Consensus Group Conference Recommendations

Managed Care Payment

Provision	Commerce-- MedicarePlus	W&M--Medicare Plus	Finance--Medicare Choices	Consensus Group Recommendation
	Secretary's projected growth in Medicare per capita spending less .5% through 2002. (No reduction after 2002)	growth in Medicare per capita spending less .5% through 2002. (No reduction after 2002)	growth plus 0.5%.	Commerce annual update.
Minimum Update	<u>1853(c)(1)(B) [p.41]</u> 0 in '98, 1% in '99 and '00, and 2% thereafter	<u>1853(c)(1)(B)</u> 2%	1% for '98 - '02	Support W&M minimum update.
Local/National Blend	<u>1853(c)(2) [p.41]</u> Phases down to 70% local and 30% national by 2002.	<u>1853(c)(2)</u> Phases down to 50% local and 50% national by 2002.	Phases down to 70/30 or 50/50.	Support Commerce 70/30 blend.
Floor	<u>1853(c)(1)(B) [p.41]</u> In 1998, \$350 or 150% of the '97 AAPCC.	<u>1853(c)(1)(B)</u> In 1998, \$350 or 150% of the '97 AAPCC.	85% of the average payment (this likely will be >\$350).	Support \$350 floor.
Cost reimbursement contracts	<u>4002 [p. 79]</u> Transition rules for Sec. 1876 appear to allow cost	<u>1002</u> Same as Commerce.	Same as Commerce.	To avoid future confusion, the conference committee should state in the

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Consensus Group Conference Recommendations

Managed Care Payment

Provision	Commerce-- MedicarePlus	W&M--Medicare Plus	Finance--Medicare Choices	Consensus Group Recommendation
	reimbursement contracts to continue.			conference report that they intend to allow Sec. 1876 cost reimbursement ontracts to continue.

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BCBSA and HIAA Conference Recommendations

Issues Regarding Medigap

Provision	House Commerce	House Ways & Means	Senate Finance (Outline)	BCBSA & HIAA Recommendations
Guarantee Issue for Under Age 65 Disabled Beneficiaries	No provision.	No provision.	Requires guarantee issue of all Medigap products to under age 65 disabled during a 6-month period when the individual enrolls in Medicare.	Oppose Finance. This provision will increase Medigap premiums to seniors -- HIAA estimates premium increases of 15% to 35%. CBO estimates Medicare outlay increases of \$300 million over 5 years.
Guarantee Issue for First-Time Medicare Plus/Choice & Select Enrollees Who Choose To Disenroll	<u>Sec. 4031(a)(3)(B)(v):</u> First-time risk or Select enrollees who previously had Medigap would be guaranteed Medigap coverage if they disenrolled within 6 months until 2002. After 2002, the time period for disenrolling would be changed to the first 3 months and at 12 months to be consistent with the Medicare Plus lock-in requirement.	<u>Sec. 10031 (a)(3)(B)(v):</u> Same, except after the year 2002, individuals are guaranteed Medigap coverage if they disenroll from plans within 3 months.	All first-time risk or Select enrollees would be guaranteed Medigap coverage if they disenrolled within 12 months, instead of 6-months.	Support Ways & Means. In order to limit Medigap premium increases because of adverse selection, the opt-out period should be limited to 6 months. PPRC data show that 2/3 of all individuals who disenroll from HMOs do so within first 6 months. A 12 month period will alter this pattern, increasing both Medicare & Medigap costs.
Guarantee Issue for Retirees in Employer-Sponsored Plans that are terminated	<u>Sec. 4031(a)(3)(B)(i):</u> When an employer retiree health plan terminates all supplemental health benefits, the retirees are	<u>Sec. 10031(a)(3)(B)(i):</u> Same.	Similar.	Concerned that this provision may discourage employers from negotiating with insurers to offer

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BCBSA and HIAA Conference Recommendations

Issues Regarding Medigap

Provision	House Commerce	House Ways & Means	Senate Finance (Outline)	BCBSA & HIAA Recommendations
	eligible.			coverage at reduced rates to all of its retirees. This provision will result in adverse selection if employers decide to offer only Medicare HMO coverage, leaving relatively sicker individuals in the Medigap market.
<p>Guarantee Issue When MedicarePlus/Choice, Medigap or Select Plan Terminates or Beneficiary Leaves for Cause</p>	<p><u>Sec. 4031(a)(3)(B)(ii),(iii), (iv):</u> Individuals disenrolling from MedicarePlus because the plan terminated; the individual demonstrates that the plan violated material provision; or the plan misrepresented policy. Select & Medigap enrollees, under similar circumstances, would be eligible for the GI requirement, unless there is provision under state law for the continuation coverage. Medigap enrollees would also be eligible if subscriber terminated due to "other involuntary termination of coverage".</p>	<p><u>Sec. 10031(a)(3)(B)(ii)(iii), (iv)</u> Same.</p>	<p>Similar.</p>	<p>The House provisions allowing guarantee issue where Medigap subscriber lost coverage due to "other involuntary termination of coverage" should be dropped since it is very broad and vague.</p>

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BCBSA and HIAA Conference Recommendations

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Issues Regarding Medigap

Provision	House Commerce	House Ways & Means	Senate Finance (Outline)	BCBSA & HIAA Recommendations
Guarantee Issue When Medicare Beneficiaries Move	<u>Sec. 4031(a)(3)(B)(ii) & (iii):</u> Individuals enrolled in risk and Select plans who move out of the service area, except for Select enrollees in states where continuation of coverage is guaranteed.	<u>Sec. 10031(a)(3)(B)(ii) & (iii):</u> Same.	Similar. However, as currently drafted, it appears that Medigap enrollees who move would be included.	Support the House provisions. Since Medigap policies are guaranteed renewable, even when individuals move, the possible Senate provision is unnecessary.
Types of Medigap Policies that Must be Guaranteed Issued in these Qualified Events	<u>Sec. 4031(a)(3)(C):</u> These individuals would be eligible to purchase Medigap plans A, B, C, or F from any insurer marketing these policies. First-time Medicare Plus enrollees could also choose to purchase the same Medigap policy they previously had. Insurers in the 3 states with waivers from the 10 standard benefit packages would issue comparable packages.	<u>Sec. 10031(a)(3)(C):</u> Same.	All individuals in these qualifying circumstances would be eligible to purchase any Medigap policy with comparable or lesser benefits to previous plan. (First-time risk enrollees who previously had Medigap, could not purchase policies with benefits greater than previous Medigap policy.)	Support House provisions with 3 changes: 1. Package F should be dropped since this would increase adverse selection; 2. Language should be added to include a "comparable or lesser benefits" test to avoid adverse selection; 3. Guarantee issue plans to first-time HMO enrollees who previously had a Medigap policy should be narrowed.
General Guarantee Issue Requirements for Above Qualifying Events	<u>Sec. 4031 (a)(3)(A):</u> Lapse in coverage may not exceed 63 days after loss of coverage. Individual must submit evidence of date of	<u>Sec. 10031(a)(3)(A):</u> Same.	Similar.	Support House provisions.

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BCBSA and HIAA Conference Recommendations

Issues Regarding Medigap

Provision	House Commerce	House Ways & Means	Senate Finance (Outline)	BCBSA & HIAA Recommendations
	termination or disenrollment with Medigap application. No preexisting condition exclusions are allowed.			
Limit Preexisting Conditions When People Become Eligible for Medicare	<u>Sec. 4031(b):</u> Bans preexisting condition exclusions during initial 6-month open enrollment period for individuals 65 and older who have had 6 months continuous coverage.	<u>Sec. 10031(b):</u> Same.	Similar.	Support House language.
New Medigap Packages	No provision.	No provision.	Authorizes new 11 th standard Medigap package with an annual \$1,500 deductible.	Do not oppose new option.
Guarantee Issue for Certain Military Retirees and Dependents	<u>Sec. 4742(b):</u> Certain military retirees and dependents would be guaranteed issue of Medigap packages A, B, C, or F.	<u>Sec. 10742(b):</u> Same.	No provision.	The House provision should drop package "F."
Means-Test Part B Deductibles	No Provision	No Provision	For individuals earning \$50,000 or more (\$75,000 for couples), the Part B deductible would rise from \$100 to at least \$540 a year.	Oppose Finance provision. When the Part B deductible rises for some Medigap policyholders (i.e., affluent seniors) Medigap premiums will rise for all policyholders,

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BCBSA and HIAA Conference Recommendations

Issues Regarding Medigap

Provision	House Commerce	House Ways & Means	Senate Finance (Outline)	BCBSA & HIAA Recommendations
				including less well-off beneficiaries. More than 1/3 of beneficiaries who earn between \$5,000 and \$15,000 a year have purchased Medigap policies.

Other Issues

Provision	House Commerce	House Ways & Means	Senate Finance (Outline)	BCBSA & HIAA Recommendations
Medicare Contractors Financial Liability for Excluded Providers	Sec. 4304: Medicare fiscal intermediaries and carriers would be held financially liable for all payments made for services provided or ordered by excluded providers.	Sec. 10304 Same.	No provision.	Oppose House provision as it places contractors at unreasonable financial risk in their role as a claims processor. Medicare contractors do not always have timely information about excluded providers.

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Consensus Group Conference Recommendations

Medicare Secondary Payer

Provision	Commerce-- MedicarePlus	W&M--Medicare Plus	Finance--Medicare Choices	Consensus Group Recommendation
MSP Time and Filing Limits	<u>4702 [p. 219]</u> Same as Ways and Means	<u>10702 [p. 262]</u> Allows the federal government to seek recovery of Medicare payments from private payers long after the claims deadline has expired and on a retroactive basis back to 1990. To allow the recovery for past stale claims and on a retroactive basis is unfair, & without precedent & likely unconstitutional (Canisius College v. United States, 799 F 2d 18 (2nd Cir., 1986); Plaut v. Spendthrift Farm, Inc. 115 S. Ct. 1447, 1496 (1995)).	Same	Change 10702(b)-- EFFECTIVE DATE.-- The amendment made by subsection (a) applies to items and services furnished after 1990. The previous sentence shall not be construed as permitting any waiver of the 3- year period requirement (imposed by such amendment) in the case of items and services furnished more than 3 years before the date of the enactment of this Act on or after the date of enactment of this Act."

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JUN 23 '97 03:38PM BCBSA OGR

Consensus Group Conference Recommendations

Medicare Secondary Payer

Provision	Commerce-- MedicarePlus	W&M--Medicare Plus	Finance--Medicare Choices	Consensus Group Recommendation
Recovery Against TPAs	4703 [p.220] Same as Ways and Means	10703 [p. 262] Allows recovery from TPAs (except when employer was insolvent) even though such TPAs should not have their own money at risk in such situations.	Same	Oppose provision to allow recovery from TPAs.

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Blue Cross and Blue Shield Association Conference Recommendations

"Kid Care"

Provision	House - Commerce	House - Ways & Means	Senate - Finance	Recommendations
Grant Mechanism	Authorizes voluntary state grants (\$2.8 bil. annually) to expand access for low-income children. Grants may be used for Medicaid expansion, vouchers for private coverage, direct purchase of services or other methods subject to approval of state plan by Secretary of HHS.	N/A	Authorizes funds (\$16 bil. over 5 years) for states to expand coverage for low-income children. States have the option of expanding Medicaid or receiving grants through Maternal and Child Health (MCH) block grant program.	Adopt Commerce, with requirement that that funds be used to expand health insurance coverage.
Insurance Standards	State programs may not deny eligibility or permit exclusions based on pre-existing conditions.	N/A	Policies funded through state program must meet state insurance standards.	Federal standards should be limited to the HIPAA provisions regarding pre-existing condition waiting periods. States should be able to impose pre-ex. waiting periods to prevent any risk selection issues that may result from gaming the program.
Benefit Requirements	Group and individual health plans providing coverage to targeted children shall include benefits (in an amount, duration, and scope specified under the plan) for at least: A) inpatient and outpatient hospital services. B) Physicians surgical and medical services. C) Laboratory and x-ray	N/A	Coverage offered through the grant option must have benefits equivalent to those under the Federal Employees Health Benefit Program (FEHBP).	Adopt Commerce -- The FEHBP benefits are very rich, and therefore expensive. The Commerce bill provides flexibility for states to maximize the number of children covered by creating benefit packages designed specifically for children.

Blue Cross and Blue Shield Association Conference Recommendations

"Kid Care"

Provision	House - Commerce	House - Ways & Means	Senate - Finance	Recommendations
	services. D) Well-baby and well-child care, including age-appropriate immunizations.			
Method of Calculating grant Allocations	States shall receive allotments based on the number of uninsured children for the fiscal year in the state (as reported through the CPS in the most recent year) and the state cost factor (based on health industry wages).	N/A	States shall receive allotments equal to the ratio of the number of uninsured children in the state to the total number of uninsured children in all states in the base period (years 1993, 1994, and 1995) as reported through the CPS.	Adopt Finance -- Commerce language would create an incentive for states to maximize their allotments by funding direct services instead of insurance programs.

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Amendments that could Reduce the Negative Impact of Medicare MSAs

1. Require budget neutrality.
 - careful risk adjustment so that healthy don't get a lot of money to build savings and funds are not drained from Medicare. (Delay start of program until risk adjustment challenge is solved.)
 - cancel the demonstration if it drains funds from Medicare.
 - don't make contributions to MSAs or investment earnings tax deductible.

2. Require that MSA funds be used *solely* for health care costs.
 - don't let people withdraw MSA funds for non-health purposes.
 - require that MSA funds left after a person dies be sent to the Medicare trust fund, not the beneficiaries' heirs.

3. Build consumer protections into high deductible insurance policies.
 - deductibles between \$1,500 and \$2,250 (as in Kassebaum-Kennedy bill).
 - cap on out-of-pocket costs of \$3,000.
 - strict regulation of private policies, including ban on underwriting of high risks and guaranteed renewability.
 - standard, comprehensive benefits package starting with Medicare benefits and adding prescription drugs.

4. Study the impact, and sunset Medicare MSAs if they are harmful.
 - independent entity such as General Accounting Office to study impact.
 - no expansion until study is done.
 - sunset program if negative effects on trust fund and quality of care in traditional program.

5. Balance Billing and Provider Participation
 - require health care providers that provide services to MSA enrollees to either agree not to balance bill or agree to limit charges to an additional 10% over Medicare recognized fees.

Briefing Materials on the EPHIC/MEWA Bill

Included are:

1. A description of the MEWAs, the EPHIC bill, and problems with the EPHIC bill.
2. MEWA Options Description.
3. An Appendix which includes:
 - The EPHIC bill - How it Works
 - Summary of Victims
 - Summary of Civil Cases
 - Summary of Criminal Cases

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

The purpose of this analysis is to discuss issues and evidence about the impact of modifying rules relating to Multiple Employer Welfare Arrangements (MEWAs), with particular focus on H.R. 1515, the Expansion of Portability and Health Insurance Coverage Act of 1997, (EPHIC).

The issues surrounding MEWAs today differ in many important respects from those faced a decade ago. The Department has issued over 70 advisory opinions since 1990, many to state prosecutors and insurance commissioners to clarify their jurisdiction over MEWAs. In the past six years, PWBA has aggressively enforced ERISA provisions over MEWAs, recovering more than \$58 million. To date, the Department has initiated 318 civil and criminal investigations of MEWAs affecting over 1.1 million participants. As of March 1997, there were 110 open investigations including 23 criminal cases.

CURRENT LAW

ERISA preempts any state law that relates to an employee benefit plan covered by Title I of ERISA. A MEWA, which is generally defined as any arrangement that provides health or other welfare benefits to the employees of two or more employers, may be an ERISA-covered plan. An exception to ERISA's general preemption rule allows state insurance laws to regulate ERISA-covered plans that are MEWAs. Thus, MEWAs may be subject to concurrent federal and state regulation under current law.

ERISA plans that are fully-insured MEWAs are subject to state insurance laws that specify levels of reserves and contributions, and to state laws for the enforcement of such standards. If a plan is a MEWA that is not fully-insured, state insurance laws may apply to the extent they are not inconsistent with Title I of ERISA. While the Secretary has limited regulatory authority to exempt non-fully-insured MEWAs from state insurance regulation, no exemption may be granted from state reserve and contribution requirements.

Arrangements that are established or maintained under collective bargaining agreements do not meet the MEWA definition under ERISA. Because these plans are not MEWAs as defined by ERISA, ERISA's general preemption rule prevents their regulation by the states.

ERISA does not require MEWAs to receive approval from federal or state regulatory authorities prior to operation. Some states require MEWAs to meet requirements, such as licensing, that apply to insurers operating in the state. Other states regulate MEWAs under statutes specifically tailored to MEWAs.

THE EXPANSION OF PORTABILITY AND HEALTH INSURANCE COVERAGE ACT OF 1997

On May 1, Rep. Fawell introduced with 113 cosponsors H.R. 1515, the "Expansion of Portability and Health Insurance Coverage Act of 1997," (EPHIC), a MEWA bill designed to

enable small firms to buy health insurance through association sponsored purchasing pools. This bill differs from Rep. Fawell's previous bill which proposed a broad federal regulatory structure with standards for provider networks and utilization review, small market reforms including premium ratings, certain requirements for self-insured plans, and provided an exemption process for certain MEWAs. This version would establish federalized regulatory and administrative procedures targeted to association based MEWAs, with limited additional reforms.

Under the bill, ERISA group health plans, including those sponsored by associations that had been in existence for 3 years, franchise networks, church plans and certain large plans sponsors could apply for certification under ERISA. The Secretary of Labor must grant certification of Association Health Plans if such certification is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of covered individuals. To be certified as an association health plan (AHP), an association sponsor must demonstrate that it is an entity with a purpose other than sponsoring an AHP, with active member support, and collects dues from members on a basis other than health status or participation in a group health plan. An AHP must offer plan participants the option of fully-insured health insurance coverage, and may also offer a self-insured option. However, any self-insured MEWA is grandfathered, ie., they would not have to offer the fully insured option. Certified AHPs would not be subject to state mandates, would experience rate based on plan, (not significantly on employer), experience, and must offer coverage to all employer members without conditioning coverage on health status, claims experience, or risk of the employers business. Self-insured arrangements must cover a minimum of 1,000 lives and maintain adequate reserves, stop-loss insurance, solvency, disclosure and plan termination standards, as specified by the statute and regulations of the Department of Labor.

The Department would administer the certification, regulation and enforcement of standards over certified plans. It could enter into cooperative arrangements with the states. Special enforcement provisions are established for: misrepresentation by an arrangement regarding AHP or collectively bargained status; cease and desist orders and for compliance with ERISA claims procedure. Special provisions are intended to clarify the status of collective bargaining arrangements, including a prohibition on use of services of a licensed agent or broker, payment of fees or commissions, annual compliance reporting, and a requirement that they be in existence for 3 years. Church plans are permitted to apply to the Department for certification, but must meet general financial standards as well as requirements of a new section establishing church plan fiduciary standards, including exclusive purpose and prudence provisions.

The bill is complex and many of its general provisions are limited by subsequent specific legislative language. A more detailed summary of the bill is included in the appendix.

PROBLEMS WITH THE EPHIC BILL

The "Expansion of Portability and Health Insurance Coverage Act of 1997," (EPHIC), a bill is ostensibly intended to allow small employers to save money by purchasing health insurance through association-sponsored plans. This legislation would federalize the regulation and oversight of Association Health Plans (AHPs), which otherwise would be covered under ERISA as Multiple Employer Welfare Arrangements (MEWAs). It may create conflicts with HIPAA's newly enacted provisions guaranteeing renewability of health insurance coverage through bona fide associations. The bill has several problems which, taken together, would undermine protections now available to workers and plans under state insurance regulation.

- ◆ **EPHICs experience rating provision would cause risk segmentation. Employer groups that join AHPs would be healthier on average than other groups and would gain at their expense.** Any insurance company and any self-insured plan offering health coverage through an AHP would be exempt from state limitations on experience rating.
 - They could "cherry pick" by varying rates for employers on the basis of age, sex, geography and other factors.
 - They could "cherry pick" outside the AHP by recruiting only "healthy members" to the association, or by marketing or organizing in only low-cost areas or historically healthy regions. Employers with an unhealthy history would be left in remaining state insurance pools, leading to ever increasing premiums in the state-regulated small group market.
 - EPHIC is not targeted to small employers; there is no size threshold for employers. In fact, AHPs can exclude employers on the basis of size of the workforce.
 - The AHP's board is given sole authority to approve applications for participation in the plan.
 - If any "individual" is a member of an association, then the employer may participate in the AHP, thus multiplying the opportunities for fragmentation of the market and risk selection.
 - "Self-insured" plans now offered by associations would be "grandfathered;" unlike other AHPs they would not be required to offer a fully-insured option.

- ◆ **Effects tied to state rating rules** - EPHIC's effects would be larger in states that impose narrower boundaries around permissible rates.
 - In such states, employers with lower than average health costs could derive savings by isolating themselves into experience-rated AHPs.
 - These savings would come at the expense of employers that remain in

state regulated small group markets.

- ◆ **Costs effects could be large** - In states with age/sex adjusted community rating, employers joining AHPs could save 24 percent while other employers' costs could rise by 7 percent, assuming that AHPs enroll 20 percent of the market. The effects would be greater in states with tighter rate regulation or if MEWA enrollment is greater.
- ◆ **Participants could be shortchanged on benefits.** Most state laws establishing benefit requirements would not apply to AHPs (except for laws prohibiting exclusion of a particular disease).
 - ◆ **Health insurance issuers and AHPs would have sole discretion** in selecting specific items and services, and excluding others from coverage.
 - ◆ **AHPs could offer limited benefit plans**, scaling down their coverage of higher cost benefits and avoiding coverage of expensive services, e.g., certain obstetrical care and mental health benefits.
 - ◆ **A loophole is created for insured plans.** An insurance company offering a scaled-down health plan through an AHP could market the same plan to employers that are eligible for coverage, but are not participating in the AHP. Although the eligible employer is outside the AHP, the plan remains exempt from state benefit laws. *[See section 2(b)(2)(D) creating 514(d)(2) of ERISA]*
- ◆ **Participants would be shortchanged on state insurance protections.** AHPs would be exempted from provider mandate laws requiring certain specialists be included in plans. AHPs' self-insured plans would be exempted from state marketing and sales standards, quality standards, solvency standards, and other consumer protections such as benefit design laws limiting out-of-pocket expenditures or lifetime limits.
- ◆ **Participants' benefits could be endangered.** The bill's solvency requirements are less rigorous than those required by the states.
 - ◆ **The bill does not require that an AHP meet capital and surplus requirements.** Although it does specify reserve standards for self-funded options, reserves are not a substitute for capital requirements. State insurance regulation has evolved beyond minimal fixed capital requirements to risk-based capital requirements that set capital standards based on the level of risk being assumed by the plan.
 - ◆ **The reserve standards in the bill are inadequate.** Certain types of reserves are not included and may be important in various circumstances. These additional reserves include contract reserves, due and unpaid reserves, and paid in advance reserves. Also, it is unclear whether incurred but not reported reserves are a part of the incurred benefit liabilities reserves requirements.
 - ◆ **The bill waives actual reserve requirements** if the AHP uses alternative means of compliance, such as letters of credit or assessments of participating

employers, that are approved by the Secretary. These alternatives are not cash or cash equivalent options and they may not be appropriate, especially if participating employers are not financially stable.

- ◆ **Savings from most of EPHICs provisions are likely to be small.** While the experience rating provisions could result in large transfers, the savings realized through other provisions are likely to be small.

- ◆ Savings from banding together already available. Some purchasing groups, such as the Health Insurance Plan of California (HIPC), already band together with significant savings under current law. Not all administrative costs would be effectively spread by AHPs, as both the AHP and issuers could incur marketing costs for each prospective employer.
- ◆ Few employers would save much by escaping state mandates. Research shows that self-insured plans, which ERISA shields from mandates, typically are no leaner than insured plans. State "bare bones" laws, which allow small employers to offer leaner benefit packages, have not been very popular, moving only 4 percent of employers to insured status.
- ◆ Few would save from nationally uniform rules. Among firms with fewer than 20 employees, just 2 percent operate in more than one state. Among firms with 20 to 49 employees, just 11 percent cross state borders.
- ◆ Self-insured AHP programs could escape certain other state charges, but these savings would be small. AHP's self-insured programs would be relieved from state premium taxes (typically only 2 percent of premium) and certain other state charges such as guaranty fund assessments (often offset against premium taxes) and assessments to subsidize high-risk pools (typically smaller amounts). These savings would be at the expense of the security of state association backing.

- ◆ **EPHIC's effects on coverage would be small.**

- ◆ Experience rating would have little effect. The availability of experience rated policies might prompt more coverage among healthier groups, but cost increases elsewhere would likely prompt coverage losses. AHPs would weaken successful state small group reforms, which ordinarily include some rating rules. Research shows that over time these reforms may prompt about 9 percent of small employers to offer coverage.
- ◆ Small savings from other provision would add little coverage. Firms that do not offer coverage tend to disproportionately employ workers who typically would turn down coverage when offered - that is who are young, earn low wages, and work part time.
 - Such firms may decline to offer coverage because employees would prefer cash wages.
 - Research shows even large price reductions would prompt only a small fraction of uninsured workers to buy insurance.

- ◆ **New categories of federally regulated single employer plans and church plans could seek certification as AHPs, creating additional opportunities for risk selection and exemptions from state consumer protections.**
 - ◆ An entirely new category of "single employer" plan can be certified as an AHP. Those arrangements not meeting the statutory exemption criteria for single employer plans would be eligible for certification as an AHP if: the majority of employees covered under a group health plan are employees of a single employer and if the remaining employees are employed by related employers (employers are related if they have common suppliers or customers).
 - The sponsorship requirements for AHPs are not applicable to these "single employer" AHPs; consequently, the sponsors do not have to be organized for a substantial purpose other than obtaining or providing medical care, or be a permanent entity that receives the active support of its members.
 - ◆ Church plans would be federalized. However, they would not be subject to federal solvency provisions; commingling of assets would be permitted, and the government would have limited ability to administer and enforce federal requirements.
 - ◆ Church plans can be marketed without restriction to individuals or employers.
 - ◆ Franchise plans could also seek certification as AHPs.
- ◆ **Insolvency provisions are inadequate.** The bill's provisions for intervention in a faltering AHP do not provide sufficient protections.
 - ◆ The bill does not establish a guaranty fund for federally certified AHPs.
 - ◆ It provides few details with respect to liquidation of plans that become insolvent.
 - ◆ There is no provision for ongoing financial examinations of self-insured AHP programs, a key component of state insurance regulation.
 - ◆ There can be critical delays in notification of financial problems. There can be a delay of up to six months from the time a plan has cash flow problems before the Secretary must be notified; this is extremely long time frame by health insurance industry standards.
- ◆ **Federal and state authorities would have limited ability to administer and enforce applicable requirements.**
 - ◆ The Secretary of Labor has limited discretion over certification of AHPs. The Secretary must certify upon finding that an AHP is "administratively feasible", not adverse to the interests of individuals covered under it, and protective of the rights and benefits of covered individuals.
 - ◆ Protections for participants and the plan are limited. Unlike ERISA's exemption procedures, there is no requirement that the exemption be in the interests of the

plan and its participants and beneficiaries (as opposed to merely "not adverse" to such interests), nor is there a requirement for notice and comment of interested parties.

- ◆ There is no provision for resources. There are vast new federal regulatory and enforcement requirements, with no provision for resources.
- ◆ State enforcement provisions are impractical. States can enter into monitoring agreements with the Department of Labor, but this enforcement is limited to one "domicile state". It would be impractical for one "domicile" state to monitor an AHP's activities in another state.
- ◆ State insurance regulation would be hampered. The state insurance market would be fragmented, making regulation of insurers more difficult.

MEWA OPTIONS

In general, two options are summarized that would provide the basis for a limited number of MEWAs to obtain federal exemption from certain state benefit mandates, thus serving as demonstration program. The first is an administrative exemption process, the second is legislative exemption process. Few MEWAs would probably take advantage of the first option, as few would qualify. It is a strategic option that answers criticisms that the Department has not done all it can administratively, and complaints that the MEWAs face high costs due to state mandates. It would probably result in an increase in the number of requests for advisory opinions under ERISA. The second option would result in an enormous expansion of the Secretary of Labor's responsibilities, and would be expensive to administer and enforce. There would be a need to address revenue sources to fund these responsibilities, including alternate sources of funding through assessments or user fees on exempted MEWAs.

OPTION I.

ADMINISTRATIVE OPTION: EXEMPT CERTAIN MEWAS FROM STATE INSURANCE REGULATION

Current law provides the Secretary of Labor with limited authority to exempt certain MEWAs from state insurance laws, except those regarding reserve and contribution requirements under section 514(b)(6)(B) of ERISA. This authority is limited to arrangements which would be "ERISA plans" under Title I, and therefore would limit the number of arrangements which could avail themselves of exemptive relief. ¹ We do not believe that many MEWAs would qualify as ERISA Title I plans for this purpose. A limited number of employer association plans with specific common interests may qualify for this exemption. MEWAs that do qualify as Title I plans could be exempted under this authority and could be relieved from state benefit mandates, but remain subject to state solvency standards.

The procedure and conditions for an exemption would be established by regulation. Such a regulation would specify conditions for issuing an exemption. Such a procedure could provide that before granting an exemption the Secretary would have to make findings that the exemption would be: (1) administratively feasible, (2) in the interests of the plan and its participants and beneficiaries, (3) protective of the rights and benefits of participants and beneficiaries of the plan. Among factors that the Secretary could consider:

- ◆ The extent to which the MEWA's benefits reflect a credible range of benefits for a health benefit provider, as determined, in part, by the reasonable expectations of participants;

¹MEWAs typically are not sponsored or controlled by employers or employer association existing for bona fide purposes other than providing health insurance and thus do not constitute a plan for purposes of Title I of ERISA.

- ◆ Who controls the MEWA; the procedures and limitations, if any, for selecting successors, and whether it is controlled by its members or by an entrepreneur, and;
- ◆ Details concerning the background and qualifications of persons controlling and administering the MEWA and the MEWA's service providers, and any requirements for successors.

OPTION II.

LEGISLATIVE OPTION: PROPOSAL TO PERMIT LARGE FINANCIALLY SOUND ASSOCIATIONS TO SPONSOR MEWAs

This option entails passing a new statute that would establish exemption procedures whereby the Secretary could exempt self-insured, ERISA-covered MEWAs, from state insurance regulation.

As discussed above, current law provides the Secretary with limited exemption authority under section 514(b)(6)(B) of ERISA; and includes any state insurance law, except those regarding reserve and contribution requirements. However, this authority is limited to ERISA plans and it is likely that few MEWAs would qualify for an exemption under the current statutory framework. Consequently, this option would provide that a broader range of MEWAs, including certain plans that might not otherwise qualify as ERISA plans, could be exempted from State law, including solvency requirements. This would permit a controlled opportunity to evaluate federal regulation of these entities, while limiting the number and risk presented of the exempted groups. The new provision would include solvency requirements, and would mirror the Secretary's existing authority to issue exemptions from ERISA's prohibited transaction provisions. In addition to the factors discussed above, the Secretary would require:

- ◆ An opinion by an independent qualified actuary as to the adequacy of the provisions made by the MEWA for reserves, the extent of stop loss insurance covering the MEWA, the adequacy of contribution rates to support the payment of obligations over the next 12 month period, and the current and projected values of assets and liabilities for the next 12 month period. In the case of an ongoing MEWA, the MEWA would submit an audited financial statement for a prior period of time. There could be a "grandfather rule" whereby provisions of state insurance laws would not apply for 18 months to a MEWA which filed for an exemption, so long as the application was not materially deficient.

Our strategy is to structure this option carefully, in order to narrowly define the composition of MEWAs initially eligible for exemption. Only larger, well-established, financially sound association sponsors will meet the conditions for exemption, as a means of controlling how the exemption/certification process will operate. After an evaluation of the original phase, the

process could later be revised by broadening the eligibility standards to allow smaller, more recently established associations to sponsor these federalized MEWAs.

Qualification for an exemption will require that MEWAs be sponsored by employer associations and that they meet criteria established by the Secretary such as:

(A) Plan sponsor requirements - the association must: (1) be able to demonstrate a minimum level of at least 500,000 to 1 million employees of members²; (2) have been organized and maintained in good faith for 10 continuous years with a constitution and bylaws specifically stating its purpose, as a trade, industry or professional association, or chamber of commerce or similar group; (3) provide apparent, material benefits other than health care coverage; (4) have a membership comprised primarily of employers with fewer than 100 employees; (5) be a permanent entity receiving active support of its members; (6) collect dues from members on a periodic basis without determining such amounts on the basis of health status; (7) must not correlate membership with health status, risk of employer's business or on the basis of participation in a health plan; and (8) must offer an option of fully-insured coverage;

(B) Board of Trustees - (1) the association's MEWA must be governed by a board of trustees consisting of individuals who are the owners, officers, directors, partners or employees of the participating employers; (2) the MEWA is operated, pursuant to a trust agreement, by the board, which is responsible for all operations of the MEWA; (3) the board has in effect rules of operation and financial controls, adequate to carry out the terms of the MEWA and applicable financial requirements;

(C) Financial/solvency standards - the Department would require that certain reserve, bonding, risk-based capital, termination coverage/bankruptcy guidelines and financial reporting standards be met. If it is decided to further pursue this option, we believe that the NAIC's model laws and certain applicable state MEWA statutes would comprise our base guidelines, with refinements added as necessary. The NAIC doesn't provide specific guidelines regarding levels of cash reserve, risk-based capital/surplus, or stop-loss coverage. Instead the models are used by actuaries to test what appropriate financial provisions are specific to each insurer.

(Past legislative proposals, and some state MEWA-specific statutes do specify certain threshold levels, such as an attachment point of 125% of expected claims for stop-loss insurance, or 25% of expected incurred claims and expenses for the claim year for claim reserves. However, a source at the NAIC believes that these are rough rules of thumb commonly used in the self-insured arena);

(D) Remedies - the MEWA must agree to certain specified remedies for wrongful denial

²By comparison, the NFIB claims it represents 7 million employees and 600,000 employers.

of a benefit claim, including consequential damages for any injuries incurred. As a condition of any exemption, the Secretary could require that the exempted MEWA agree to certain other provisions that would be enforceable by participants under state contract law.

(E) Coverage in poorly served areas - the association would be required to demonstrate that it offers or intends to offer health care coverage to geographic areas where health care coverage for small firms is low;

(F) Multi-state operations - the association would be required to demonstrate, at a minimum, a significant portion of its membership in at least 3 states.

(G) Prohibit discrimination in membership - except for geographic purposes or limitations approved by the Secretary, associations would be prohibited from conditioning association membership based on health status or participation in a health plan, and the association would be required to make benefit packages available on an equivalent basis (terms and price) to all of their member employers. (HIPAA currently regulates discrimination in coverage, as opposed to membership).

(H) Equivalent contributions and benefit packages - employers would have to offer benefit packages on an equivalent basis to all of their employees. Employers would be prohibited from purchasing individual coverage for high-cost employees who are otherwise eligible for MEWA coverage. Also, the non-purchase of benefits must be at the employee's affirmative election; and

(I) Guaranty association - exempt MEWAs would be required to provide a mechanism, independently or in conjunction with other exempted MEWAs, to guarantee that claims would be paid in the event of insolvency or termination. Alternatively, participating employers could be required to share in responsibility for the claims incurred by the MEWA which could not otherwise be met by contributions, reserves, stop loss insurance, or any other arrangement.

(J) Risk Pools - exempt MEWAs may be required to participate in state risk pools, as appropriate, to control for risk segmentation in the small group market.

(K) Enforcement remedies and related issues - as part of this option, certain enforcement remedies, including required registration, cease and desist orders for failure to comply with state insurance or federal certification provisions, would be included in any legislative proposal. Other items that should be included would be legislative definition of a collective bargaining plan

Breadth of Preemption

A federal exemption would have the effect of removing many state insurance and other laws from applicability to exempted MEWAs. However, eligible MEWAs and related parties should be continue to be subject to certain state regulation.

Exempted MEWAs would be relieved from certain state benefit mandates.

In formulating a strategic option in answer to EPHIC, it is clear that the bill's exemption from state benefit mandates must also be included in the Department's structure, in order to gain any degree of support from the NFIB, the Chamber of Commerce, etc. However, they would remain subject to coverage of state laws prohibiting an exclusion of a specific disease from coverage.

Exempted self-insured MEWAs would be relieved from state premium taxes.

Again, in order to gain any support for DOL's structure, self-insured MEWAs should be exempt from state premium taxes. Although state guaranty fund assessments and state premium taxes are interrelated in that insurers may write off guaranty fund assessments against premium taxes, generally premium taxes are used for general revenue purposes.

Marketing Limitations would apply to exempted MEWAs.

Insurance agents would continue to be subject to state insurance licensing laws and exempted MEWAs would only be able to market policies to their members.

MEWAs could be overseen by an independent self-regulating agency.

An alternative to an extensive DOL system of regulation would involve developing a framework for an independent third party to regulate/certify MEWAs, similar in design to NASD Regulation Inc., the entity recently established as the regulatory arm of the National Association of Securities Dealers Inc., or the National Committee for Quality Assurance³. This could be a self-funded administrative structure through assessments or dues. Generally, the agency would include representatives from the disciplines of insurance, actuarial science and certified public accounting. The Department of Labor would oversee the administration and enforcement of the self-regulating agency. This option would require that the following be included in an exemption application:

³The NCQA is an independent, not-for-profit organization that analyzes and reports on the quality of managed care plans, including HMOs. It is governed by a Board of Directors that includes employers, consumer and labor representatives, health plans, quality experts, regulators, and representatives from organized medicine.

- A statement of actuarial opinion, signed by a qualified actuary, that contribution rates are not excessive, are not unfairly discriminatory, and are adequate to provide for the payment of all obligations and the maintenance of required reserves and surplus for the 12 month period beginning 120 days before the date of the application;
- A statement of the current value of the assets and liabilities accumulated under the arrangement and a projection of the assets, liabilities, income and expenses of the MEWA for the same 12 month period as above;
- A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves and other expenses;
- Other provisions as specified by the Secretary of Labor.

Ongoing monitoring procedures are necessary and should include reporting and disclosure requirements. In addition, the regulatory agency could be given investigatory powers. Examples of monitoring methods include:

- Requiring MEWAs to maintain detailed records, including specified information. The records could include audited financial and actuarial statements; projections of future liabilities, etc.
- Requiring MEWA sponsors to determine and report on a periodic basis whether the plan is meeting financial requirements imposed (if any). For example, previous legislation required that the operating committee of each plan must determine semiannually whether the plan is meeting certain reserve requirements included in the bill.
- Requiring plans to report operations to the regulatory authority on a periodic basis;
- Requiring periodic review of the MEWA by the regulatory authority.

The Department would have to monitor and enforce the adequacy and fairness of the independent regulating body in any case, and it could be inappropriate as a matter of policy to delegate too much authority. However, using a third party entity would relieve the Department from significant administrative and regulatory burdens related to various options under consideration.

APPENDIX

- A. The EPHIC Bill - How it Works.**
- B. Summary of Victims.**
- C. Significant MEWA Civil Cases.**
- D. Significant MEWA Criminal Cases**

5/29/97

THE EXPANSION OF PORTABILITY AND HEALTH INSURANCE COVERAGE ACT OF 1997 - HOW IT WORKS

On May 1, Rep. Fawell introduced with 113 cosponsors H.R. 1515, the "Expansion of Portability and Health Insurance Coverage Act of 1997," (EPHIC), a MEWA bill designed to enable small firms to buy health insurance through association sponsored purchasing pools. This legislation would establish federalized regulatory and administrative procedures for certified association-sponsored MEWAs. Certain MEWAs that are ERISA group health plans, including those sponsored by associations that had been in existence for 3 years, franchise networks, church plans and certain large plan sponsors could apply for certification under ERISA.

The Secretary of Labor must grant certification of Association Health Plans if such certification is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of covered individuals. Unlike ERISA's exemption procedure, there is not a requirement of a finding that it be in the interests of the plan and its participants and beneficiaries, (as opposed to merely not adverse to such interests), nor is there a requirement for notice and comment of interested parties. The Secretary must establish class certification requirements.

To be certified as an association health plan (AHP), an association sponsor must demonstrate that it is an entity with a purpose other than sponsoring an AHP, with active member support, and collects dues from members on a basis other than health status or participation in a group health plan. Specific additional sponsoring association criteria include:

- ◆ Organized and maintained in good faith, with a constitution and by laws stating its purpose;
- ◆ Has periodic meetings at least on an annual basis;
- ◆ Can be a trade association, industry association, professional association or chamber of commerce or similar organization acting on a cooperative basis. (with reference to section 1381 of the IRC). It appears that a group of individuals can constitute an association for sponsoring a plan.
- ◆ Franchise networks are deemed to meet the requirements of an association for purposes of sponsoring a plan, and each franchise deemed to be a member of the association.
- ◆ Certain collectively bargained plans can be deemed to be an association for purposes of sponsoring a plan, if they fail a revised 3(40) definition discussed below. They are also deemed to meet participation and coverage requirements noted below.

To be certified as an association health plan, an AHP must offer plan participants the option of fully-insured health insurance coverage, and may also offer a self-insured option.

(Note: self-insured association MEWAs in existence on April 1, 1997 are apparently

grandfathered, ie., do not have to have the core offer of a fully-insured MEWA.) The AHP must meet certain additional criteria for a certification:

- ◆ The sponsor, (together with immediate predecessor) has been in continuous existence for a period of 3 years;
- ◆ The plan is operated by a board of trustees, pursuant to a trust agreement, which has complete control over the plan;
- ◆ The board of trustees has rules of operation and financial controls based upon a 3 year plan of operation, adequate to carry out requirements of ERISA;
- ◆ The board of trustees must be individuals selected from owners, officers and directors, or employees of employers, but certain limitations on membership apply to contract administrators or service providers to the plan;
- ◆ The board has sole authority to approve application for participation in the plan and to contract with a service provider.

There is an exception from the association provisions for certain plans not meeting the single employer requirement, where a majority of the employees covered under the health plans are employees of a certain employer and all other employees covered are employed by employers who are related to that larger employer by virtue of sharing a common ownership or common business operations based on common suppliers or customers. These plans would appear to be eligible to seek certification as an AHP.

All AHP participating employers must be members or affiliated members of the sponsor association.

- ◆ In the case of a professional association, or individual based association, if an individual or partner of an employer is a member, their employer may participate in the AHP.
- ◆ All individuals covered must be active or retired employees of participating employers or beneficiaries.
- ◆ Affiliated members must be affiliated as of the date of certification or been uninsured for 12 months prior to joining the AHP coverage.
- ◆ Participating employers can not offer employees coverage in the individual market similar to coverage provided to other employees, if such exclusion is based on health related factors and the individual would otherwise be eligible for coverage.
- ◆ The group health plan can exclude employers on the basis of size of the workforce, or on the basis of participation or contribution requirements as permitted in the HIPAA amendments to the Public Health Service Act, PHSA section 2711.
- ◆ Benefit options must be marketed to all eligible participating employers.

All AHPs must meet certain additional requirements:

- ◆ There must be a written plan document with a board of trustees serving as a named fiduciary.
- ◆ There must be a named plan sponsor (within 3(16))

Contribution rates must be non discriminatory. But

- ◆ Contribution rates may not vary significantly on the basis of claims experience of the employer. (*This language allows employer rating within the association on the basis of individual employer claims experience*).
- ◆ Contribution rates do not vary by industry or business in which employer is engaged.
- ◆ An AHP or health insurer may vary contribution rates based on the claims experience of the plan, notwithstanding any other provision of law. (This appears to preempt state rating laws for association plans)

Benefit Options: A health insurance issuer and an AHP may limit or select benefit options notwithstanding any state law or anything in this Part (8);

- ◆ They have sole discretion in selecting specific items and services consisting of medical care to be included as benefits in under such plan or coverage;
- ◆ Except: for any law that prohibits exclusion of a specific disease;
 - ◆ mental health parity provisions or newborn and mothers coverage to the extent not preempted by HIPAA.

Financial Solvency Provisions; [Separate provisions benefits under the plan consisting solely of health insurance coverage (insured), and AHP additional benefit options which to not consist of health insurance provisions.(self-insured).

For Plan including additional benefit options not consisting of health insurance coverage (self-insured):

- ◆ Self-insured plans must have no fewer than 1000 participant and beneficiaries.
- ◆ Must maintain reserves sufficient for unearned contributions, incurred but unpaid benefit liabilities, and an additional reserve for other obligations in an amount recommended by the qualified actuary.
 - ◆ Reserves not less than the greater of 25% of expected incurred claims and expenses or \$400,000.
- ◆ Excess stop loss insurance for the plan with an attachment point no greater than 125% of expected gross annual claims. (Secy may regulate the basis for expected claims for reserves and stop loss.)
- ◆ The plan shall secure a means of indemnification of claims which the plan cannot satisfy due to termination.
- ◆ A qualified actuary must include a margin for fluctuations and error in determining the amounts of reserves
- ◆ The Secretary may set additional requirements relating to reserves, and excess stop/loss insurance, and may adjust the levels of reserves to take into account excess stop loss insurance.
- ◆ Secretary may provide for a *hold harmless* arrangement or other arrangement to enable plan to meet its obligations.
- ◆ *Self-insured plans would apparently be exempted from state premium taxes by due to the modifications to ERISA's preemption provisions.*

The Secretary is given authority to adjust the levels of reserves otherwise required for insured and self-insured plans to take into account excess/stop-loss insurance.

Certification application must include the following:

- ◆ A filing fee of \$5,000, available for administering the certification provisions.
- ◆ Identifying information including the sponsor and the board of trustees of the plan.
- ◆ The states in which it the plan intends to do business and number of participants in each state.
- ◆ Evidence ERISA's bonding requirements are being complied with.
- ◆ Plan documents governing the plan.
- ◆ Agreements with service providers and contract administrators.
- ◆ For plans offering benefit options in addition to health insurance coverage, a statement of actuarial opinion about adequacy of reserves, contribution rates, current and projected value of assets and liabilities, cost of coverage to be charged including administration costs, and other information required by the Secretary.
- ◆ Written notice to states in which at least 25% of participants are located.

Certified plans are subject to certain additional disclosure requirements, including:

- ◆ A notice of any material changes in information required as part of the certification.
- ◆ An annual report
- ◆ An opinion of a qualified actuary on the plan.

Termination: plan shall secure a means of indemnification of claims the plan cannot satisfy in case of termination.

- ◆ Plan must notify participants and beneficiaries not less than 60 days before proposed termination.
- ◆ Develops a plan for winding up the affairs of the plan and submits the plan to the Secretary.

Corrective Actions and Mandatory Termination

- ◆ A certified AHP, providing benefits other than health insurance coverage, must continue to meet solvency and reserve requirements irrespective of whether the certification continues in effect
 - ◆ Trustees must determine quarterly whether these requirements are met.
 - ◆ If there is a failure to meet these requirements, the board must notify the plan's actuary, which must make recommendations to the Board on corrective actions
 - ◆ The Secretary must be notified within 30 days of receiving recommendations of the actuary, and the Board must regularly report to the Secretary on corrective actions taken.
- ◆ Following notice, mandatory termination of the plan must be ordered by the Secretary where there is a reasonable expectation that the plan will continue to fail

to meet funding and solvency requirements.

- ◆ The trustees must take the actions required by the Secretary to terminate the plan.

Special rules for church plans maintaining a group health plan.

- ◆ Church plans can elect to be covered under this section with respect to benefits provided under the plan consisting of medical care, notwithstanding ERISA's section 4(b)(2) exclusion for church plans.
 - ◆ A church includes a convention or association of churches, or a plan established and maintained for employees of a church.
 - ◆ No other provision of ERISA is made applicable to church plans.
- ◆ All state laws regulating insurance are preempted for church plans under these provisions.
 - ◆ Church plans are not deemed to be insurance companies for purposes of state law.
 - ◆ Premium rate regulation and benefit mandate laws are specifically preempted to the extent they are for AHPs.
- ◆ Special ERISA-like requirements are established for church plans.
 - ◆ A church plan fiduciary shall discharge his duties subject to the exclusive purpose rule, with the care of a prudent man, subject to the plan documents (generally restated here from section 404 of ERISA).
 - ◆ Assets may be commingled with church assets, so long a separate accounting is provided.
 - ◆ A claims procedure is required, in accord with the Secretary's regulations, (restated here from section 503 of ERISA), and participants are provided written descriptions of the procedure.
- ◆ Annual statements filed with the Secretary include identifying information, certification of compliance with fiduciary rules and claims procedures, states in which participants will be located, and include an actuary's statement indicating adequacy of financial reserves. The annual statement is to be made available by the Secretary to state insurance commissioners.
- ◆ Enforcement only by the Secretary under the injunctive authority of 502(a)(5), except that no civil action may be brought other than a temporary restraining order, unless the plan fails to correct its failure within the correction period described in 3(33)(D), (generally, at least 270 days). Certain other ERISA enforcement provisions may also apply.
- ◆ *Note: There is no specific provision for church plans applying for certification, nor are there solvency, administrative, termination, or*

reporting provisions applicable except as noted above. There do not appear to be any limitations on whom church plans can market to except as noted above.

Rules of Construction

- ◆ Defines group health plan, medical care, health insurance coverage, health insurance issuer, health status related factor, individual market, participating employer qualified actuary and applicable state authority, as generally consistent with ERISA as amended by HIPAA.
- ◆ Defines employer and employee as including an individual who is a partner or a self-employed individual.
- ◆ Plans maintained to provide medical care for individuals, which demonstrate to the Secretary that they meet certification requirements, shall be treated as an employee welfare benefit plan for purposes of this title.

Preemption: All state laws are preempted insofar as they preclude a health insurance issuer from offering health insurance coverage in connection with a certified AHP.

- ◆ A health insurance insurer may offer health insurance coverage of the same policy type to other employers operating in the state which are eligible for coverage under an association, whether or not such other employers are actually participating employers in the plan; Supercedes any state law precluding such coverage.
- ◆ Health insurance policy coverage policy forms filed and approved in a particular state in connection with an insurer's offering under an AHP are deemed to be approved in any other state in which such coverage is offered, when the insurer provides a complete filing in the other state.
- ◆ Clarifies the authority of the state to regulate self-insured MEWAs which are not AHPs

Control Group:

Modifies the treatment of certain single employer arrangements under ERISA by modifying the control group definition in 3(40). A single employer plan is excluded from the definition of a MEWA, (and thus from state law) by defining the minimum interest required for two or more entities to be in "common control" as a percentage which cannot be required to be more than 25%. A plan would also be considered to be a single employer plan if less than 25% of covered employees are employed by other participating employers.

Collectively bargained arrangements are redefined:

Arrangement established or maintained under a collective bargaining arrangement as described in the NLRA, the RLA, or the state public employee relations laws. Eliminates requirement for Secretary to find the arrangement is a collective bargaining arrangement. Additional conditions must be met to be a statutorily excluded collectively bargained arrangement.

- ◆ No services of a licensed insurance agent or broker
- ◆ Maximum of 15% non employees; grandfathers arrangements with as many as 25% individuals who are not present or former employees
- ◆ Certify annually
- ◆ If not fully insured, then must be a multiemployer plan under LMRA
- ◆ Employee organization must have been in existence for 3 years if not in effect on date of enactment.

The Department would administer the certification, regulation and enforcement of standards over certified plans. It could enter into cooperative arrangements with the states.

- ◆ The Secretary's authority to investigate and initiate civil actions for enforcement of certification requirements can be delegated to states so long as it doesn't result in a lower level or quality of enforcement.
- ◆ The Secretary must ensure that only one state is recognized as the primary domicile state for delegation of enforcement authority over any particular association plan.

Enforcement provisions over association health plans are created, as follows:

- ◆ Criminal penalties are established for willful, willful blindness or false representation that a plan or arrangement is a certified association plan, or has been established or maintained under a collective bargaining agreement under section 3(40) as amended.
- ◆ A cease and desist order shall be entered by a court requiring that a plan or arrangement cease activities upon application of the Secretary showing that
 - ◆ the operation, promotion, or marketing of an AHP is not certified under these provisions, or
 - ◆ is subject to state insurance laws and is not approved under the insurance laws of such state or
 - ◆ is certified, but not operating in accordance with the terms of the certification.
 - ◆ The association health plan or other arrangement can defend that it is operating in accord with state laws in each state in which it is offering benefits;
 - ◆ The court may grant additional equitable relief.

The association health plan must require the board of trustees to ensure that the claims procedure requirements of ERISA are met.

Effective dates:

- ◆ Immediately effective are the clarification of single employer arrangements and collectively bargained plans.
- ◆ The provisions establishing the association health plans, certification, trustee, participation and coverage, plan documents, contribution rates, notices,

termination provisions, and church rules, are effective on January 1, 1999.

- ◆ Section 801(a)(2), describing the term association health plan as relating to a group health plan that offers an insured health option, does not apply to group health plans (self-insured) which exist on April 1, 1997, which do not provide health insurance coverage on that date, but later qualify for certification.

Summaries of MEWA Cases

U.S. Department of Labor

April 15, 1997

SIGNIFICANT MEWA CIVIL CASES

Reich v. Isely

States affected: Wisconsin, Illinois, Ohio, Nevada and California.

The National Employee Benefit Fund, an organization run by Peter R. Heckman and related parties, left participants with outstanding claims of about \$750,000. When the organization closed there were 500 remaining participants. Peter R. Heckman, the operator of the fund and fund trustees allegedly failed to establish employer contribution levels sufficient to pay benefits and administrative expenses and failed to maintain adequate reserves to cover accrued liabilities. The trustees also allegedly paid excessive administrative expenses. Whole life policies (which were more expensive for the plan) were purchased rather than group term in order to generate increased commissions for a plan fiduciary.

A 1995 settlement recovered \$575,000 for participants from the defendants, insurance and other sources.

Reich v. Dealers Association Plan

States Affected: Georgia, Ohio, North Carolina and South Carolina

Approximately 1,300 participants were left with approximately \$1 million in unpaid claims as a result of three failed MEWAs sponsored by Independent Automobile Associations in Georgia, North/South Carolina, and Ohio and administered by Dealers Association Plan (DAP). DAP, specifically one M. L. Vaughan, was a fiduciary and service provider to the MEWAs and contributed to the failure of the health plans by collecting insufficient premiums to pay both claims and anticipated administrative expenses. In addition, no actuarial studies were performed, asset reserves were not maintained, and administrative expenses were excessive. DAP also engaged in self-dealing through its receipt of commissions for the sale of life insurance.

On February 12, 1997 the U.S. District Court for the Middle District of Florida Orlando Division issued a final judgment and order granting the Plaintiff's motion for summary judgment against defendant M. L. Vaughan. Specifically, Vaughan is permanently enjoined from acting in any capacity with ERISA plans and is ordered to make over \$1.5 million in restitution to the three MEWAs.

Reich v. Wilhite

States Affected: California, Arizona

About 1,500 participants in the Independent Automobile Dealers Association plan had about \$1 million in unpaid claims because the plan's assets were allowed to be depleted down to only \$150,000 through

improper administration of the plan. The trustees of the plan committed numerous violations of ERISA when they maintained insufficient reserves in the MEWA, failed to set sound actuarial rates and paid excessive administrative expenses to the plan administrator, DAP (see above). A Special Master has been appointed by the court to take over the day to day operations of the plan including the settlement of unpaid claims and negotiating claims reductions with service providers. \$375,000 has already been paid into a settlement fund and an additional 267,000 is expected to be paid in to resolve the remaining unpaid claims.

Metzler v. Wolfe et al.

States Affected: All 50 states

The International Professional Craft and Maintenance Employees Association (IPC-MEA) was a purported union which sponsored the IPC-MEA health trust which collapsed in mid-1996 with at least \$2.3 million in unpaid claims. The Department initially filed a complaint against the plan's trustees and others alleging that the union was a sham and that the plan had been run imprudently causing it unviability. A temporary restraining order (TRO) was obtained and an independent trustee was appointed to marshal the plan's remaining assets and process claims.

In February 1997, the complaint was amended to include additional defendants. Settlement negotiations are ongoing.

Reich v. Jones

States Affected: Approximately 35 states, primarily Florida and Georgia

Approximately \$4.5 million was recovered to pay the unpaid claims of 12,000 workers employed by the leasing company Action Staffing in a settlement obtained by the Department. Lawrence Jones, the former president of Action Staffing, which also maintained a group health plan, marketed it to numerous employers, principally in the south. He also was permanently enjoined from serving as a fiduciary to ERISA-covered plans.

Reich v. Goebel

States Affected: California, New York

This involved a William Loeb related entity which was forced out of business by the California Department of Insurance. The entity was also the subject of a civil lawsuit brought by the Department against plan fiduciaries Leo and Janice Goebel, which resulted in the Goebels being barred from involvement with ERISA plans. The defendants allegedly engaged in numerous ERISA violations in administering health plans of the National Council of Allied Employees LU 444. Local 444 purported to be a labor union, but conducted no union activities apart from the management and sale of employee benefits. The defendants failed to actuarially determine proper contribution rates, failed to hold plan assets in trust, and dealt with plan assets for their own benefit.

Reich v. Hanson

States Affected: New York

Approximately \$700,000 in outstanding premiums and \$600,000 in outstanding claims were owed to some 560 employers covering 1,800 participants when their insurance was retroactively canceled by Blue Cross. Blue Cross and Blue Shield of Central New York and the plan's trustee failed to inform employers and subscribers that health insurance premiums were not paid in a timely manner. Ultimately, the failure of the fund's trustee to pay the fund's insurance premiums to Blue Cross resulted in the retroactive cancellation of health coverage. The plan's trustee was charged with mismanaging premiums of client plans, transferring the funds to companies controlled by him, and failing to comply with plan rules.

Martin v. Kirel

States Affected: Arizona

In a parallel civil lawsuit, the Department obtained nearly \$185,000 in restitution for the welfare plan of United Labor Council Local Union 615. Earlier, an independent receiver was appointed and accounts were frozen for the union. Since its inception a majority of the plan's funds were diverted to benefit fund officials and service providers, their spouses, and to other entities controlled by them, to pay for non-claim expenditures. Fund money was used for luxury cars, personal credit card expenses, and non-fund related legal expenses.

Martin v. Beltz

Affected States: California, Texas and Florida

Restitution of \$520,000 was ordered to be distributed to the eligible 8,500 participants of the Diversified Industrial Group Health and Welfare Plan (DIG). DIG's plan was ordered terminated by a federal court after the Department sued DIG and its principals. The defendants allegedly violated ERISA by failing to: obtain actuarial studies, to obtain or use appropriate underwriting procedures, to maintain sufficient asset levels and reserves, and to pay reasonable fees.

Martin v. T.P.A., Inc.

Affected States: 40 states

Court judgments were obtained against the defendants in June, 1995. Judgments were obtained to repay \$1 million for unpaid medical claims owed to 8,500 participants in 40 states. Trustees and administrators of the Group Rental Insurance Plan (GRIP) were charged with failure to pay approximately \$9.5 million in medical claims. They allegedly did not obtain and utilize actuarial data in setting contribution rates, failed to maintain asset levels and sufficient reserves, falsely represented GRIP as an ERISA plan, failed to review the selection and performance of service providers, and paid excessive and improper administrative expenses.

Martin v. Loeb

Affected States: New York, Oklahoma, Florida

Full restitution was recovered for approximately 150 participants who had \$200,000 in unpaid claims owed by the welfare plan of the National Council of Allied Employees International Union (NCAE) Local 412. Loeb and another defendant were removed as trustees of the welfare fund and barred from serving ERISA plans. The union was barred from chartering new local unions. (Previously, the two had been removed from their positions with the Local 867 Consolidated Welfare Fund; see Martin v. Goldstein). The Department found that the trustees of NCAE fund failed to obtain actuarial and other relevant information to determine proper rates, used fund assets to market the benefits, failed to assure proper claims processing and allowed claims to go unpaid. They also were charged with numerous self-dealing and conflict of interest violations, including the use of fund assets by Loeb for gambling activities. Another union, local 615, also chartered by NCAE, was the subject of similar allegations. (See Kirel)

Martin v. Burton Goldstein

States Affected: California (primary) and Florida, Texas, New York, New Jersey, Arizona, Missouri, Louisiana, Illinois, Arizona, Ohio, Oklahoma and Connecticut

At its peak, the Local 867 Consolidated Welfare Fund had approximately 10,000 participants until terminated in December 1991 with unpaid claims in excess of \$6 million. Burton Goldstein, William Loeb and others engaged in misrepresentation, self-dealing and other fiduciary violations of ERISA. The fund was terminated in 1991. An alleged sham was organized by Loeb purportedly for the sole purpose of selling health insurance. The trustees were charged with misrepresenting the amount by which benefits were insured by Empire Blue Cross, marketing benefits to persons located outside of Empire's coverage area thus causing Empire to cancel coverage and refusing to pay claims. Other charges involved imprudent funding and administration of the fund.

The Department obtained a settlement agreement under which Goldstein would make partial restitution, and he and two corporate defendants were permanently barred from involvement with ERISA covered plans. Prior settlements were reached with the remaining defendants in the case.

Two individuals connected with the Local 867 Consolidated Welfare Fund, William Loeb and Harvey Glick, have also been the subjects of criminal prosecution. Loeb was convicted and sentenced to 71 months in prison and ordered to make restitution of \$494,000. Prosecution involving Glick is ongoing.

Reich v. International Association of Entrepreneur of America (IAEA)

The complaint along with a temporary restraining order was filed on April 12, 1996 in the Middle District of Tennessee.

The PWBA investigation leading to the suit was based on complaints from the Arkansas and South Carolina insurance departments concerning the operations of the International Association of Entrepreneur of America (IAEA) which sponsors a welfare fund marketed throughout the United States. The offered benefits are split between workers' compensation and health benefits. The split, initially, was about 95% workers'

compensation and 5% health benefits; more recently, the ratio has altered to about 90% workers' compensation and 10% health benefits.

The defendants are: (1) IAEA, which purports to be a non-profit employer association under ERISA. It is administered out of Irving, Texas; (2) IAEA Benefit Trust, which is a MEWA administered out of Nashville, Tennessee; (3) IAEA Inc., which under a contract with IAEA, actually performs the functions that IAEA provides to the Trust; (3) James E. Taylor and Joseph N. Fiore: each are 50% owners of IAEA, Inc. (NB: Taylor and Fiore once served as trustees to the LU 615 Welfare Fund which was the subject of our litigation styled *Reich v. Kirel*) (4) Ross N. Fuller, hired by Taylor and Fiore to be trustee of the IAEA Benefit Trust. (5) Stockton Fuller & Company, Inc. (Stockton Fuller), a corporation 98% owned by the minor son of Ross Fuller. Stockton Fuller claims to be an investment manager under ERISA.

The complaint includes allegations that: (1) Defendants "diverted" over 20% of employer contributions collected (over \$4.5 million) to themselves or others; 2) "Compensation" of Taylor, Fiore, and IAEA, Inc. is "excessive"; (3) No actuarial studies made to determine adequacy of contributions: (3) Stockton Fuller hired without competitive bidding and Stockton Fuller decided its own compensation.

The complaint seeks to: (1) Remove defendants from fiduciary positions and appointment of an independent fiduciary pendente lite with plenary authority; (2) Enjoin defendants cooperation with independent fiduciary; (3) Correct prohibited transactions; (4) Require an accounting and related records-production; and (5) Freeze assets of principal defendants.

SIGNIFICANT MEWA CRIMINAL PROSECUTIONS

U. S. v. Gazitua

On 11/19/92, 2 separate indictments were returned charging Gazitua and 4 other defendants with multiple count violations involving embezzlement from employee health benefit plans (18 U.S.C. § 664), kickbacks relating to employee health benefit plan operations (18 U.S.C. § 1954), RICO (18 U.S.C. §§ 1962, 1963), Money Laundering (18 U.S.C. § 1957), Forfeiture (18 U.S.C. § 982), Conspiracy (18 U.S.C. § 371), Mail (18 U.S.C. § 1341) and Tax Fraud (29 U.S.C. § 7206(2)). The five defendants were: John Gazitua, George Doherty, April Marie McGlawn, Kenneth Rutter and Robert Searle.

Gazitua was a former consultant to and one of the founders of the now defunct International Forum of Florida Health Benefit Trust (IFFHBT). IFFHBT was a multiple employer welfare arrangement (MEWA) which offered attractively priced insurance policies to small businesses by pooling employees and spreading the risk. The indictments charged Gazitua and the other defendants with skimming money from premiums and creating shell corporations to provide false services and then pocketed fees from services that weren't provided. The indictments alleged that the defendants fraudulently collected more than \$34 million in health care premiums and cheated more than 40,000 workers of more than \$50 million in medical claims. This has been described as one of the largest health-care insurance frauds in history. Doherty was the chief trustee; Rutter, McGlawn and Searle were service providers. Doherty, and Searle entered guilty pleas on 12/28/92. Doherty pled guilty to 15 counts involving Conspiracy, RICO, Mail Fraud, Kickbacks and Embezzlement. McGlawn pled guilty to conspiring with Doherty to defraud the trust through Embezzlements, Kickbacks and Money Laundering. Searle pled guilty to aiding in the preparation of a false corporate tax return and he admitted to conspiring with others to embezzle employee benefit plan funds. They were sentenced 4/22/93 as follows:

- DOHERTY: 80 months imprisonment, 3 years supervised release and was held accountable for restitution of \$34,000,000 in premiums;
- SEARLE: 2 years imprisonment, 1 year supervised release;
- McGLAWN: 6 months home confinement, 2 years probation and ordered to pay back restitution of \$111,795.

Kenneth Rutter, an independent insurance agent, went to trial. After a six day trial, beginning March 8, the jury returned a verdict of not guilty.

On March 8, John Gazitua pled guilty to 15 counts involving violations of Conspiracy, Embezzlement from Employee Benefit Plans, Mail Fraud, Kickbacks Relating to Employee Benefit Plan Operation, Money Laundering and RICO. June 16, Gazitua, was sentenced to 97 months imprisonment followed by a 2-year term of supervised release, and was ordered to pay \$34,496,000 in restitution. At sentencing, Judge Sharp equated Gazitua's conduct with that of Michael Milken. (MIAMI, OLR, and IRS/CID)

U. S. v. Hay

On November 4, 1993, a seven-count indictment charging Henry Hay, 61, of Orange, Ca., with mail fraud in connection with his marketing and administration of several group health insurance plans, and Joseph Bartholomew, 54, of El Toro, Ca., with aiding and abetting.

Beginning in the early 1980's, Hay designed, sold and administered employee health benefit plans covering employees of small employers. He operated through his company, Health Data Processing Insurance Administrators, Inc. (Health Data), a corporation in the business of administering employee health benefit plans, and two trusts that he established which held premiums paid by employers and paid medical claims. During this period, the only insurance policy the BET had, was a "stop-loss" policy with Lexington Insurance Company (Lexington).

Hay embarked on a scheme aided by Bartholomew, to obtain money through fraudulent representations. The alleged fraudulent activity was accomplished by: 1) creating the impression that the plans were fully insured, instead of having only "stop-loss" type insurance; 2) withholding payment of claims; and 3) diverting premiums to Hay's personal use.

In 1986, Hay negotiated with John Detora, a Vice President with Lexington, to switch the "stop-loss" insurance from Lexington to Landmark Insurance Company (Landmark), an affiliate of Lexington. In exchange for Detora's assistance, Hay agreed to pay kickbacks to Detora. (Detora was the subject of a prior successful government prosecution.) Although, Landmark provided only "stop-loss" insurance, Hay informed his sales staff that the health plans were fully underwritten by Landmark. The same information was distributed in brochures produced and distributed by Hay and his staff. In April 1988, when the existing policy expired, Landmark refused to renew it. Hay, however, failed to inform insurance agents and employers that the plans had no insurance coverage. The next month, May 1988, Hay negotiated an agreement with Bartholomew, through which CBL would provide insurance only to selected employers who purchased the plans prior to August 1988 and whose premiums would be held by PET. However, the details of the agreement made clear that PET would pay virtually all claims. Also, Hay agreed to pay CBL a fee so that he could use CBL's name in marketing the plans. Later, in December 1988, Bartholomew, gave Hay lucrative contracts to administer CBL and to broker reinsurance for CBL. In return, Hay paid kickbacks to Bartholomew. In February 1989, Bartholomew, at Hay's request, signed a letter representing to the

California Department of Insurance that the Plans were fully insured. In June 1989, CBL was closed pursuant to a state court order obtained by the California Department of Insurance, because CBL lacked sufficient assets to operate as an insurance company.

As a result of the scheme, BET and PET received in excess of \$17,000,000 in premiums. Hay diverted in excess of \$1 million to his personal use: salary, loans, expenses. Subsequently, HAY filed a bankruptcy petitions for BET and Health Data, and ceased operating PET, leaving over \$6 million in unpaid claims. Trial started in February and is on-going.

U. S. v. Ullah

Hameed Ullah, aka, Tony Ullah, a MEWA operator, was indicted on money laundering and asset forfeiture charges on May 3, 1995. Two associates were previously indicted in connection with the alleged fraudulent operation of the MEWA and have pled guilty. (U.S. v. White & Nanning)

Allegedly, Ullah and others, doing business through 15 entities, operated a scheme to defraud employers and their employees of the health coverage programs that falsely purported to pay medical claims through MEWAs. He received monies from at least 2,500 employers, representing approximately 4,000 workers. These workers and their employers, were continually advised by mail and in phone conversations, that benefits would be paid. However, Ullah continued to refuse to pay approved claims and told his employees to pay only the "hot" claims, those involving the press, litigation or regulatory agencies. Several victims stated that they were in constant contact to have claims paid but to no avail. Thirteen State Departments of Insurance and PWBA received complaints from approximately 130 participants. Further, Ullah, his entities and employees, have been the subject of at least 11 cease and desist orders filed by State Insurance departments. At October 1993, there were about **\$3.2 million in unpaid claims**. Subsequent to the search, PWBA investigators executed seizure warrants at California banks and almost \$500,000 was seized from Ullah accounts. Additional action pending.

U. S. v. Kenemore

On April 4, 1995, a 24 count indictment was returned charging Lawrence D. Kenemore, Jr, 50, his wife, Sherlyn D., 40, both of Arlington, Tx., his son Joseph B., 31, of St. George, Utah, and 5 other individuals: Michael J. McKeown, 41, Los Angeles; Chris W. Kellum, 29, his wife Crystal, 24, both of Carlisle, Pa., Vernon Byrd, Ft. Worth, and Charles E. Postle, 61, Irving, Tx., charging them with conspiracy, embezzlement from employee welfare benefit plan funds totalling \$936,000, mail fraud, making a false statements to the Department of Labor, and money laundering,

Lawrence Derwood Kenemore, Jr., was the Manager and Controller ATG Association of Trust and Guarantee (ATG) created by the defendants and used to market a fraudulent benefit program. Sherlyn Denice Kenemore assisted Lawrence and represented herself to be Secretary of ATG. Joseph Bryan Kenemore represented himself to be Secretary-Treasurer of the National Employees Trade Association Local 101 (LU 101) and trustee for the LU 101 trust fund. Wayne J. McKeown represented himself to by president of LU 101. Chris Wayne Kellum represented himself to by Secretary-Treasurer of the National Employees Trade Alliance (Alliance) and trustee for the Alliance trust fund. Vernon L. Byrd represented himself to by the President of Affiliated Guilds of America (AGA). Charles E. Postle represented himself to be Secretary-Treasurer for AGA and trustee for the AGA trust fund. CRYSTAL KELLUM, served as Office Manager and Bookkeeper for ATG.

The National Employees Trade Association Local 101, National Employees Trade Alliance, and the Affiliated Guilds of American were created by the defendants who represented them to be labor unions. In fact, they were sham unions.

Allegedly, the defendants conspired to commit mail fraud by using employee benefit plans and non-existent unions to market and sell worker compensation and health benefits. Further, the defendants set up an employer association and used entities that they represented to be labor unions to induce employers to contribute money to the defendants by falsely representing that such contributions would be deposited into trust funds to provide compensation and health coverage for the employees of the contributing employers and falsely represent \$1 million in workers compensation coverage per employee. They also created National Claims Administration (NCA) and represented it to be a third-party administration company. NCA was represented to be independent of ATG and the unions, and would review claims of injured workers to determine which were valid and eligible for payment. However, NCA was used to deny and/or delay payment of workers compensation and health claim of employees.

The indictment charges that between April 1, 1993 and August 31, 1994, the defendants received employer contributions of approximately \$1.7 million, of which approximately \$300,000 (or less than 18%) were deposited into the welfare benefit plans. Approximately \$1.4 million (or more than 82%) of employer contributions were used by the defendants and others for their own use.

This criminal action is the result of a joint investigations conducted by PWBA's Dallas office, the FBI, IRS Criminal Investigation Division, and the Texas Attorney General's office.

KENEMORE has been the subject of civil suits filed by Departments of Insurance in Arizona, Colorado, Florida, Georgia, Illinois, Michigan, Mississippi, North Carolina, North Dakota, Texas and Utah. Also, KENEMORE was the subject of a civil action filed January 18, 1995. *Reich v. Kenemore*, 3-95-CV-105-R, (N.D. TX, 1/18/95). The suit asks for more than \$1.3 million in restitution.

On January 31, 1995, the Court found that ATG represented a substantial threat to the public at large and issued a preliminary injunction barring ATG, KENEMORE, and others from any continued involvement with ERISA plans. The Court also froze all of the assets of ATG and KENEMORE and appointed a receiver with authority to marshal plan assets, liquidate the plan, and manage the plan for the benefit of the participants and beneficiaries.

Investigation disclosed that ATG marketed health and workers' compensation benefits programs through a series of sham labor unions which it created. These so-called labor unions performed virtually none of the traditional functions associated with legitimate labor unions such as negotiating wages, working conditions, holidays, etc. These arrangements were really schemes to sell insurance without supervision by state insurance departments.

ATG, operating under Kenmore's direction, adopted purported collective bargaining agreements (CBAs) with three such labor unions operated by persons related to ATG. In a typical scenario, individual employers would sign an association agreement with ATG. Under the terms of the association agreement, the employees of the subscribing employer were covered by the CBA. ATG collected both union dues and plan contributions from participating employers.

Kenemore has a history of misappropriating insurance premiums. Prior to setting up ATG, Kenemore operated Los Angeles-based Bestland Insurance Agency, Inc. Bestland was placed in receivership on March

30, 1993, at the request of the California Insurance Department, for repeated violations of California insurance laws. In October 1993, a California Superior Court ordered the liquidation of Bestland, stating that its officers had "embezzled, sequestered, or wrongfully diverted" Bestland's assets and that the continued operation of Bestland would be "hazardous to its policyholders, creditors, and the public". ATG began operations on March 30, 1993, the same day that Bestland was shut down by the California Insurance Department.

The investigation leading to civil suit filed by the Plan Benefits Security Division was conducted by PWBA's Kansas City office.

SUMMARY OF VICTIMS

U. S. Department of Labor
April 15, 1997

Done Right Electric
Kansas

The company is a small electrical contractor employing 17 people. It purchased health insurance for its workers through the MEWA, Contract Services Employee Trust (CSET). Due to CSET's default in paying health benefits, the company and all of its employees were directly affected in several ways. The default financially devastated three employees -- two who had to file personal bankruptcy because of outstanding medical bills for as much as \$67,000. Now employees must pay out of pocket for an alternate family health insurance policy which offers reduced health benefits. The company's 401(k) and medical savings account were terminated. The company was forced to pay drastically higher premiums in order to obtain replacement health insurance.

Tri-State Trophy
Mississippi

An owner of the company needed heart bypass surgery. He wound up paying a portion of the \$90,000 owed by the MEWA which was sponsored by Local 615. The MEWA folded and did not pay his medical benefits. The company subsequently obtained health insurance coverage for its 10 employees, but only by excluding the owner with the medical problem.

Androscoggin County Chamber of Commerce
Maine

An employee with the Androscoggin County Chamber of Commerce and her husband had medical insurance with Atlantic Staff Management, a Maine employee leasing company which marketed a health plan to hundreds of small employers throughout **Maine and New Hampshire**. The couple's unpaid medical claims, incurred in May 1994, totalled \$58,000. Atlantic is a failed MEWA that closed its doors in 1995 leaving millions of dollars in unpaid medical claims. Atlantic refused to return their calls, gave them the run-around when they were able to speak with someone and still never paid the bills. The couple was badgered by collection agencies for a year. They cannot afford to pay the bills.

Sam's Bakery
Maine

Sam's Bakery leased employees from now-defunct Atlantic Staff Management. Atlantic is an employee leasing company based in Maine which sponsored a MEWA providing health and other benefits. The ERISA-covered MEWA was marketed to hundreds of small employers throughout **Maine and New Hampshire**. An employee of the bakery elected health coverage from the MEWA. He incurred substantial medical bills after going in and out of the hospital for about a year with a bad back and broken neck. The MEWA failed to pay his medical expenses, thereby leaving him with outstanding medical bills of approximately \$28,000.

Tulare County Bar Association
California

The Bar Association operates a MEWA that provides medical and life insurance benefits to member attorneys and their employees. The MEWA, while partially self-funded, was underfunded. This resulted in unpaid claims of \$222,861. One participant alone had \$50,000 in unpaid bills owed for pre-approved brain surgery. That participant contacted the Department about getting her claims paid, which was done shortly after the Department intervened on her behalf. In a letter of appreciation, she wrote: "I was just married ... and thanks to you and the Department of Labor, I don't have to worry about this \$50,000 debt over my shoulders." Other outstanding claims were later paid in March 1996.

California

J&S Enterprises

The former owner of this small business purchased the CDMA plan -- a MEWA which provided health insurance. When the owner had a heart attack, the CDMA verified his coverage but did not pay the estimated \$60,000 in medical bills. He also required cardiac treatment which had to be discontinued because the bills were not being paid. He was harassed by bill collectors and he ultimately took a second mortgage on his home to pay his creditors. The MEWA went bankrupt in 1989 leaving its victims without insurance and \$6.6 million in unpaid health benefit claims. Its principal, Henry Hay, was criminally charged and sentenced for his role in the health care scheme.

* * * *

The owners of a "mom and pop" grocery store also purchased the CDMA plan. When both their sons were involved in an automobile accident, the plan failed to pay any of the approximately \$400,000 in medical bills incurred. The family also was harassed by bill collectors and had to hire an attorney.