



**BlueCross BlueShield  
Association**

An Association of  
Independent Blue Cross  
and Blue Shield Plans

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## **VHIAs – MEWAs BY ANOTHER NAME - WOULD DESTROY STATE SMALL GROUP REFORMS**

### **Questions and Answers on the VHIA Provisions In H.R. 3103**

#### **Is there a difference between Multiple Employer Welfare Arrangements (MEWAs) and Voluntary Health Insurance Associations (VHIAs)?**

- No. VHIAs are a type of MEWAs.** Specifically, VHIAs are MEWAs that purchase insured coverage (i.e. coverage provided by licensed insurance companies).
- Health plans offered by trade or industry associations or Chambers of Commerce are all examples of VHIAs/MEWAs.

#### **What special treatment do VHIAs receive under H.R. 3103?**

- VHIAs would be exempt from state laws that prohibit experience rating of VHIAs ( these laws require insurers to pool **all** their small groups in order to assure the maximum cross subsidy of risk.)
- In addition, H.R. 3103 generally would exempt VHIAs from state mandated benefit laws.

NOTE: H.R. 3103 allows states to regulate some VHIAs if the state reforms meet certain criteria. However, even in these states, VHIAs that existed prior to 1996 and all multi-state VHIAs would be exempt from state mandated benefits and experience rating laws. It would be very easy to establish a multistate VHIA. Only New York and New Jersey could regulate small group coverage sold by **any** VHIA.

#### **Why would VHIAs destroy state small group reform efforts?**

- VHIAs would circumvent the goal of small group reform laws -- to provide cross-subsidization of all small groups -- by segmenting their healthier small employers away from the general insurance pool. This would result in higher premiums for groups still in the general insurance pool.
- When employees of small groups covered by VHIAs did become ill, the small groups could reenter the general insurance pool to obtain needed mandated benefits because of guaranteed issue requirements -- further exacerbating adverse risk selection.



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### **How would VHIA's "cherry pick" healthier members?**

- VHIA's could use benefit design to assure a healthier risk pool. VHIA's would not be required to offer coverage for many services that other insurers must provide due to state mandated benefit laws (i.e. Autologous Bone Marrow Treatments (ABMT) for cancer). These benefits are costly and critical to less healthy individuals -- literally on a life and death basis. As a result, less healthy groups would avoid VHIA coverage and participate in the general insurance pool. Conversely, VHIA's could attract healthy people -- like young families -- by designing benefit packages to specifically meet their needs (i.e., first dollar orthodontia coverage or targeted preventive services).
- VHIA's that fell under the general exemption in the House Leadership bill could structure membership criteria to attract the healthiest groups -- they would not have to accept all small groups as members and could limit membership to healthier industries and avoid those occupations that are known to have higher claims experience.
- Multi-state and "grandfathered" VHIA's could selectively market membership in their organization to healthier populations. For instance, they could market only in suburban areas where most people are healthy and working and in parts of a state with lower health costs.

### **Do small employers need VHIA's to avoid state mandated benefits?**

- No.** Currently, a majority of states have laws that allow insurance carriers to waive mandated benefit laws in order to offer "no frills" insurance coverage for small employers.
- More importantly, if there is a federal imperative to relieve small businesses from the burdens of state mandated benefits, then why not preempt mandated benefits for *all* small employers, not just those that purchase coverage through VHIA's?

### **Would VHIA's result in larger pools of small employers?**

- No.** VHIA's would fragment the current, broad small group insurance pool by creating more and more, smaller and smaller pools of employers as healthier groups joined VHIA's to separate themselves from the rest of the insured market.

### **Is federal legislation necessary for VHIA's to operate?**

- No.** VHIA's are operating today -- but they are regulated by the states. Federal legislation with special rules for VHIA's only would provide competitive advantages for VHIA's over other insurers in the market.

Blue Cross and Blue Shield Association  
Office of Policy and Representation  
May 7, 1996



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## **WHO'S WORRIED ABOUT A FEDERAL TAKEOVER OF MEWA REGULATION?**

**□ The Department of Labor (DOL):**

*"....There have been other MEWAs that have been chameleon like, going from state to state, taking premiums and leaving the employees holding the bag. This has been a really serious problem for us in terms of being able to track these kinds of entities. We think the states are better capable of that." --  
Meredith Miller Deputy Assistant Secretary DOL*

**□ National Governors Association (NGA):**

*"MEWAs have been controversial for a number of years and states, along with the federal government, have made great strides in assuring the efficacy and legality of these arrangements. No such guarantees would exist if they are moved solely to federal oversight." 3/5/96 letter*

**□ National Association of Insurance Commissioners (NAIC):**

*"It is troublesome that H.R. 995 has chosen to promote pooling by expanding ERISA exemptions to include MEWAs when many of these arrangements have had significant problems both in terms of their financial viability and the propensity for scam operators to take advantage of gaps in federal laws."  
3/5/96 letter*

## **WHY ARE REGULATORS OPPOSED TO A FEDERAL TAKEOVER OF MEWA REGULATION?**

**□ 1992 GAO report documents numerous problems, including:**

- MEWAs left at least 398,000 participants and their beneficiaries with over \$123 million in unpaid claims in 29 states alone between January 1988 and June 1991.
- More than 600 MEWAs failed to comply with state insurance laws and some violated criminal statutes, including fraud and embezzlement, between January 1988 and June 1991.
- In 1988, a California-based MEWA began enrolling Florida residents without the knowledge of officials of the state of Florida. Within a year, the MEWA had enrolled about 4,000 people. It paid a few small claims but failed to pay any large ones, ultimately accumulating \$3.2 million in unpaid claims. Florida officials shut down this MEWA in 1989, with no identifiable assets.

□ **1992 Study by the Senate Permanent Subcommittee on Investigations found:**

- "MEWAs were bilking unsuspecting employers and employees of millions of dollars, leaving tens of thousands of working people with worthless insurance and unpaid medical bills."
- In Texas, seven MEWAs left unpaid claims and monetary judgments in excess of \$19 million.

□ **In 1994 alone, MEWA problems surfaced in numerous states including:**

- North Carolina reported that there had been a total of \$4.4 million in unpaid claims from MEWAs.
- In Oklahoma, a MEWA left \$1.3 million in unpaid claims and 5000 participants stranded,
- In Mississippi, the MEWA legacy was \$785,000 of unpaid claims and 600 subscribers uncovered.
- In Dallas, \$1,000,000 in unpaid claims were left from a MEWA that had covered as many as 20,000 people.

Blue Cross and Blue Shield Association  
Office of Policy and Representation  
March 20, 1996



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## **QUESTIONS AND ANSWERS ON MEWAS**

### **What are MEWAs?**

Multiple Employer Welfare Arrangements (MEWAs) are a type of purchasing pool currently regulated by the states. These entities provide health benefits for employees of two or more employers. Health plans offered by trade or industry associations or Chambers of Commerce are all examples of MEWAs.

MEWAs can self-fund or purchase insurance. States currently have regulatory authority over MEWAs and require self-insured MEWAs to comply with state insurance standards because they are risk bearing entities and look and operate just like other insurers.

### **Is the House Leadership bill necessary in order for MEWAs to exist?**

No. MEWAs already operate in the insurance market and are regulated by the states like other risk-bearing entities. When regulated properly by the states, MEWAs can indeed assist small employers in getting health coverage.

### **Are the House MEWA provisions necessary to provide small employers with the same advantages as large employers in terms of ERISA preemption?**

Currently, there are no restrictions on the size of firm that can self-fund their benefits and obtain exemption from state law through ERISA. Small employers can, and do, self-fund in today's marketplace.

### **What is the difference between a large employer self-funding and a group of small employers self-funding through a MEWA?**

There are several important differences. First, large employers cover only their own employees. These employees are unlikely to drop coverage unless they leave the employer. In contrast, MEWAs cover multiple employers who can leave the arrangement at any time in search of a better deal -- creating a very unstable pool.



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Second, large employers can draw upon their assets to pay claims. MEWAs depend on an adequate cash flow from member premiums because they have no corporate assets upon which to draw. As a result, adequate reserve standards are critical.

Finally, and most importantly, large employers select new hires based on their ability to perform a needed role in the firm. An employer's desire for high quality personnel would override any incentive to select based on health status. MEWAs, however, can structure their membership criteria to attract a healthier population.

### **Are insurers just afraid to compete with MEWAs?**

No. We support vigorous competition among all entities providing health care benefits. We oppose, however, the federal government choosing market winners. Exempting MEWAs from state regulation would provide them with a significant competitive advantage over licensed insurers and HMOs. Federal preemption would allow MEWAs to escape state rules that require fair rating, solvency and quality standards and minimum benefit packages. All of these regulations protect consumers, but they also add to the cost of coverage.

We believe that MEWAs provide a range of important services for employers. MEWAs provide benefits, pay claims, collect premiums and spread health costs over all small employers in the pool. We think these are valuable services -- it's called insurance. MEWAs, therefore, should be subject to the same state standards as other health insurance carriers.

### **Does the federal government need to step in because the states are not adequately regulating MEWAs?**

No. According to the NAIC, 17 states have separate statutes regulating MEWAs and the remainder regulate them through existing insurance laws. A number of states have taken the additional step to require licensed agents, brokers, third-party administrators and insurers to submit information to the Insurance Department prior to assisting MEWAs with insurance transactions.

### **Will fewer MEWAs face bankruptcy under this legislation because it includes solvency standards?**

No. First of all, the Department of Labor has indicated that they do not have the resources necessary to oversee regulation of MEWAs -- that is, they do not have enough personnel to enforce MEWA solvency standards.

Second, the House Leadership bill provides significant latitude for the MEWA to use other financial arrangements to meet the reserve requirements. The bill

allows the MEWA to substitute other controversial financial arrangements for all or part of the reserve requirements, with the Secretary's approval. The Secretary can take into account letters of credit, which are very controversial in the industry, or other evidence in determining whether a MEWA meets its financial obligations.

### **How can MEWAs risk select when they are required to accept all members?**

First, the legislation does not explicitly prohibit self-insured MEWAs from varying the premium rates of their members based upon demographics, health status, duration or industry group -- factors that are regulated by the states. Therefore, MEWAs could attract the healthiest risks by charging higher premiums to employer groups with sicker individuals.

Also, MEWAs can structure membership criteria to attract the healthiest groups - they can limit membership to a healthy industry (i.e., personal fitness trainers). MEWAs also can risk select through benefit design. It is easy to attract healthy people -- like young families -- by designing the benefit package to specifically meet their needs (i.e., first dollar orthodontia coverage or preventive services).

In addition, MEWAs can risk select through marketing practices. They can market only in suburban areas where most people are healthy and working. They also can avoid advertising during the day when unemployed individuals are at home or in neighborhoods where the population is older and sicker.

### **The majority of the uninsured work for small employers. Is exemption of MEWAs from state law necessary to make coverage more affordable for small employers?**

No. Preemption of MEWAs from state regulation would have just the opposite effect. It would result in premium increases by unraveling state insurance reforms and fragmenting the market. The movement of healthy groups into MEWAs would leave high risk individuals in the insurance pool and reduce the number of people over which to spread the high claims costs. This would result in higher premiums for groups still in the insurance pool.

### **Is an exemption for MEWAs from state regulation necessary so small employers can avoid those expensive state mandated benefits?**

No. Currently, a majority of states have laws that allow insurance carriers to waive the mandated benefit laws for a product in the small group market. These "no frills" policies have realized some success in attracting previously uninsured small employers.

**Will there be less fraud in MEWAs with federal regulation as opposed to state regulation?**

No. The House Leadership bill would require a substantial new federal bureaucracy to monitor and assure the solvency of MEWAs across the country. The DOL has stated that it "simply does not have the resources to carry out the substantial new responsibilities" that would be required if the House Leadership bill's MEWA provisions became law. The DOL also has pointed out that solvency and consumer protection standards in many state statutes are more stringent than the standards in the House Leadership bill. As a result, the federal legislation would "weaken" MEWA enforcement.

**Is it true that the House Leadership bill would allow states to regulate MEWAs if they have small group market reform?**

Only two states, New York and New Jersey, would be allowed to regulate small group coverage sold by all MEWAs under the House Leadership bill.

An additional 16 states would be able to regulate small group coverage sold by certain new MEWAs. These states, however, could not regulate new MEWAs that claim they will cover 7,500 participants at some point in the future. (This provides a tremendous opportunity for gaming since any MEWA can claim the expectation of 7,500 participants in the future.) MEWAs operating prior to 1996 also would be outside state authority.

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## **MEWAs: THE UNRAVELING OF STATE INSURANCE REFORMS**

As Congress considers federal health insurance reforms, Congress **should reject** proposals to grant special federal rules for extending ERISA preemption to Multiple Employer Welfare Arrangements (MEWAs).

Under the guise of allowing employers to join large purchasing groups to lower health care costs, these proposals would result in **large premium increases for small employers and individuals** by unraveling state insurance reforms and fragmenting the market.

### **What Are MEWAs?**

Multiple Employer Welfare Arrangements (MEWAs) provide health benefits for the employees of two or more employers who have joined together. Health plans offered by trade or industry associations, or Chambers of Commerce are all examples of MEWAs.

MEWAs can self-insure or purchase insurance from plans which are regulated by the states. States currently have regulatory authority over MEWAs and require self-insured MEWAs to comply with state insurance standards because they are risk bearing entities, and look and operate just like other insurers.

### **Impact of Congressional Proposals to Provide an ERISA Preemption for Self-Insured MEWAs**

Certain congressional proposals, such as Congressman Fawell's bill (H.R. 995), would preempt self-funded MEWAs from state regulation, and transfer oversight to the Department of Labor (DOL). These entities would be exempt from state regulations including: fair rating rules, solvency and quality standards, minimum benefit laws, and premium taxes. Only minimal federal standards would replace comprehensive state rules. This would:

- Destroy the Integrity of State Small Group Reforms and Increase Premiums:** Preemption of self-funded MEWAs from state regulation would destroy the integrity of small group reforms as an increasing percentage of the carriers in the small group and individual markets could escape state regulation. The movement of healthy individuals into self-funded arrangements would leave high risk individuals in the insured pool, but reduce the number of enrollees over which to spread the high claims costs. The resulting premium increases would drive away more healthy individuals and ignite another round of premium increases. States would be unable to stabilize rates because such a large portion of individuals would be outside their authority.



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SENT TO ALL  
MEMBERS OF CONGRESS

May 15, 1996

The Honorable Bill Bradley  
United States Senate  
Washington, DC 20510-3001

Dear Senator Bradley:

I am writing to express opposition to the provisions in The Health Coverage Availability and Affordability Act, H.R. 3103, that establish preferential treatment for Multiple Employer Welfare Arrangements (MEWAs) and Voluntary Health Insurance Associations (VHIAs) -- a type of insured MEWA. This legislation would exempt MEWAs from all state law and VHIAs from the costs of state small group reform laws related to experience rating as well as state mandated benefits (including many women's and children's health issues such as maternity care, pap smears and well-child care).

The complicated series of exceptions to exceptions in the House provisions regarding VHIAs has created a great deal of confusion. Ultimately, all multistate and grandfathered VHIAs would be exempt from state mandated benefits and rating laws (except in New York and New Jersey). In addition, all other VHIAs (i.e. new, non-multistate VHIAs) would be exempt in about half the states from mandated benefits and experience rating laws.

If these MEWA/VHIA provisions are included in the conference agreement, the Blue Cross and Blue Shield Association will have no choice but to *oppose ultimate passage of this bill* because of the negative implications on the beneficial small group reforms enacted by states in recent years. H.R. 3103's important reforms regarding portability of health coverage should not be undermined by including these controversial and problematic MEWA/VHIA provisions. We are opposed to these provisions because:

- **Congress should not create an "uneven" playing field.** Under H.R. 3103, the federal government is picking a "market winner" by granting competitive advantages to insurers offering coverage through VHIAs over other insurers. VHIAs would have an immediate pricing advantage because they could avoid the costs of state mandated benefits and could "cherry pick" the healthiest risks.



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- H.R. 3103 fails to limit the ability of VHIA's to avoid the sick and target the healthy. For instance, VHIA's could selectively market association memberships -- how would bricklayers know about the Association of Aerobics Instructors' health plan if it is advertised only in aerobics magazines? Also, by evading coverage of expensive state mandated benefits like maternity care and autologous bone marrow transplants, VHIA's will avoid high cost enrollees who need these services.
- **State small group reform initiatives will not work if VHIA's are exempt from state law.** Congress should not undermine the states' ability to reform their markets by allowing VHIA's to evade important state laws. States have determined that small group reform will not work unless insurers are required to pool the claims experience of all small employers together in one pool. Otherwise, healthier groups will become separated from sicker, high cost groups. The states will quickly be back where they were before reforms were enacted -- wide differentials between the premium rates of small employers and an unstable small group market.

We urge you to consider the grave public policy consequences of this very complicated, controversial provision. We look forward to working with you to pass health care reform, but we intend to vigorously oppose any legislation which includes special treatment for VHIA's or MEWAS by any other name. If we can provide assistance to you as the conference committee moves forward, please contact me at (202) 626-4780. We have enclosed a document for your information that answers many questions regarding VHIA's.

Sincerely,



Mary Nell Lehnhard  
Senior Vice President

Attachment

**Cost Impacts of the MEWA Provisions of the Health Coverage Availability  
and Affordability Act of 1996**

**Executive Summary**

**Part I**

**William Custer, Ph.D.**

**Georgia State University Research Center for Risk Management and Insurance**

**Part II**

**Gordon Trapnell, F.S.A.,**

**President of the Actuarial Research Corporation**

**(formerly the Senior Actuary for the Medicare program)**

**James Mays**

**Actuarial Systems Analyst, Actuarial Research Corporation**

**Cathi Callahan**

**Actuary, Actuarial Research Corporation**

The goal of the Health Coverage Availability and Affordability Act of 1996 (H.R. 3103), passed by the House of Representatives on March 28, is to improve access to insurance coverage. However, the bill undermines its small group reform and individual market access initiatives by extending ERISA preemption of state law to certain multiple employer welfare arrangements (MEWAs). An analysis of these MEWA provisions indicates they will:

**Generate Up To \$1.6 Billion In Potential New Federal Regulatory Spending**  
Even if only 10% of current Associations take advantage of the new MEWA ERISA preemptions, regulatory costs to the Department of Labor could increase by as much as \$1.6 billion over a budget cycle of 7 years. If 3% of current Associations opt to sponsor federally regulated MEWAs, federal regulatory costs could increase by as much as \$0.5 billion.

These regulatory costs stem from a conservative estimate that between 737 and 2,212 national self-funded MEWAs would offer coverage, and between 1,329 and 4,312 Voluntary Health Insurance Associations (insured MEWAs) would take advantage of the ERISA preemption. Currently there are 22,500 national associations in operation, and 48,000 organizations with a regional, state or local scope of members.

#### **Undermine the Effectiveness of Small Group Insurance Reform**

The portion of H.R. 3103 providing partial and complete exemptions from state law for MEWAs works at cross purposes with the intent of the rest of the legislation as well as state efforts to reform their small group markets. The potential numbers of MEWAs are large as are the opportunities for risk segmentation.

#### **Have Little Effect on the Uninsured**

It is unlikely that many of those insured through newly created MEWAs or VHIAs would be drawn from the previously uninsured. Instead, MEWA subscribers would be drawn largely from those who are insured currently in the small group market. Those previously insured individuals that do subscribe with MEWAs are expected to be healthier than the average individual.

#### **Increase Premiums By As Much As 30% For Insured Individuals**

Tightly regulated individual insurance markets could experience premium increases of up to 30% as a result of adverse selection if MEWAs attract 35% of the individual insurance market. Small group insurance rates could increase up to 16% in these markets. Less tightly regulated markets could see increases of as much as 24% in the individual market and 13% for small group coverage.

#### **Increase Risk Pool Assessments up to 34% for the Small Group Market**

Shifts of insured groups and individuals from a regulated market to MEWAs would decrease the ability of states to fund high risk pools and other insurance programs. In order to compensate for the loss of revenue from MEWA participants, assessments would have to increase from up to 34% on the insured small group market and from up to 22% on the insured individual market.

### **Attract Healthier Groups Than The General Insurance Pool**

MEWAs may take advantage of current membership criteria that attract healthier groups, or restructure requirements to reach this goal. Other risk selection opportunities include, but are not limited to benefit design, marketing practices, and wide premium variations between groups based upon demographic or industry category.

In fact, the primary decision factor behind the formation of MEWAs will be its ability to attract a healthy population. As a result we would expect good risks to flow into MEWAs leaving poorer risks to be insured in the general insurance market or by no means at all. Since MEWAs are likely to attract the healthier risks, premiums in the insurance market should be higher than they would be in the absence of MEWAs. The precise increase in premiums would vary on a state by state basis, depending on the market penetration of MEWAs as well as the presence of small group reform.

## **A Description of Actuarial Research Corporation**

Actuarial Research Corporation (ARC) is a privately held corporation with offices in Annandale, Virginia, and Columbia, Maryland, founded in 1974 by Gordon R. Trapnell, F.S.A., a nationally recognized expert in estimating the cost of private and public health insurance programs.

The close association of ARC with its actuarial consulting affiliate, Gordon R. Trapnell Consulting Actuaries (GRTCA), provides for the synthesis of a state of the art health services research capacity and a realistic appreciation of the practical problems encountered in operating health plans and insurance operations. The primary clients of ARC are HCFA, other HHS agencies, CBO, OCHAMPUS and other federal agencies, and several state Medicaid programs. Among the clients of GRTCA are HMOs, IPAs, PPOs, Blue Cross and Blue Shield plans, and insurance companies.

Both firms have established national reputations for the high quality and reliability of the studies prepared, and for developing new, innovative actuarial techniques. GRTCA has earned a reputation for developing innovative solutions for the problems created by the rapid changes occurring in the financing of health care. ARC has established a national reputation for the high quality and reliability of the research studies prepared and for developing data bases to investigate the utilization and costs of mental health/substance abuse (MH/SA) services and other topics. The results of the research activities provide advanced insights into the direction of the rapid evolution of health care financing methods. ARC is currently making direct use of the private sector experience of GRTCA in studying alternatives to the AAPCC, assisting CHAMPUS in assessing the managed care potential of HMOs bidding for risk contracts, and assisting the States of Virginia, Vermont and Massachusetts in developing Medicaid managed care waiver programs.

## STAFF BIOGRAPHIES

### **Gordon R. Trapnell**

Gordon Trapnell is President of Actuarial Research Corporation (ARC) and Principal of Gordon R. Trapnell Consulting Actuaries, Ltd., (GRTCA). He is a nationally recognized expert in analyzing the feasibility and estimating the cost of private and public insurance programs. Mr. Trapnell has specialized in assisting innovators in developing new approaches to offering health care benefits and in research projects to determine their feasibility and effectiveness. This emphasis has enabled him to advise the Administration and the Congress concerning the potential for major changes to improve the cost effectiveness of the U.S. health system. Mr. Trapnell is especially well known for sound advice and reliable cost estimates for new programs, new features and public initiatives.

Prior to forming ARC and GRTCA, Mr. Trapnell was the senior actuary responsible for Medicare in the Social Security Administration. In this capacity, he was responsible for preparing long-range cost estimates for the Social Security programs, and for estimating the effect of proposed legislative changes to these programs.

Mr. Trapnell is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and received his B.A. in Mathematics from the University of Virginia.

**James W. Mays**

James Mays joined Actuarial Research Corporation as an actuarial systems analyst in 1979. For the past nine years, he has been directing systems development under an actuarial services contract to the Assistant Secretary for Planning and Evaluation/Health, Department of Health and Human Services. His principal duties have been in designing and implementing computer models for analyzing the effects of changes in Federal health policy. Recently, Mr. Mays has been concentrating on pricing and selection issues associated with Medicare options. In 1995 he co-authored (with Jack Rodgers) a report on medical savings accounts (MSA) for Medicare beneficiaries. He has also been analyzing the effects of MSAs on the under-65 population for the Department of Health and Human Services. During 1993 and 1994, Mr. Mays provided technical assistance on questions developed by the Clinton Administration's Health Care Reform Task Force. His primary areas of involvement were in development of the financial models used for examining alternative financing systems under a national system, with special attention to the determination of relative plan richness for proposed coverages compared to current employer-sponsored insurance levels, and analysis of the market impacts of alternative rating systems in regional health alliances. Mr. Mays holds an M.S. in Computer Science from the University of Virginia.

**Cathi M. Callahan**

Cathi Callahan, an actuary with ARC has a background in mathematics with an emphasis in economics. For the past ten years, she has worked with many of the major micro data bases used in health services research. Her principal duties have been in implementing computer models for analyzing national health expenditure patterns and employer-sponsored insurance benefit payments. Ms. Callahan provided technical support to the Department of Health and Human Services in their analyses of the Clinton health reform plans. Earlier, Ms. Callahan provided technical assistance on questions developed by the Health Care Task Force. Her primary areas of involvement were in the determination of relative plan richness for proposed coverage packages compared to current employer sponsored insurance levels, and analysis of the impacts of alternative rating systems in HIPCs. For the Office of National Health Statistics (ONHS), Ms. Callahan has worked on developing a data base for the Special Policy Analysis Model (SPAM). The data base was created using the March Current Population Surveys and the 1987 National Medical Expenditure Survey, and projected using data from the National Health Accounts. It has been used for preliminary estimates and analysis of health expenditure patterns and reform proposals. Ms. Callahan is an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries, and holds a B.S. in Mathematics, from The College of William and Mary in Virginia.



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American Economic Association,  
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National Academy of Social Insurance  
National Advisory Council, March of Dimes' Strategies for Improving Worksite  
Maternal and Infant Health  
Board of Directors, National Association of Health Data Organizations  
Research Advisory Board, American Compensation Association

RESEARCH AND SCHOLARLY ACTIVITIES

Publications

In Refereed Journals

"Health Care Policy Reform: The Effects of Health Care on Business and Labor" *Journal Of Research in Pharmaceutical Economics*, Vol. 5, No. 3 (1994)

"The Cost of Providing Health Care Benefits to Early Retirees under the Health Security Act" with Paul Fronstin, Sarah Snider and Dallas Salisbury, *Health Affairs* Spring, 1994

"The Shifting Health Care Reform Debate: How Much, How Quickly and When" with Dallas Salisbury, *ACA Journal* Vol. 2, No. 3 (Winter, 1993)

"Health Care Reform: Its Significance for Employers" with Jill Foley, *ACA Journal* Vol. 1, No. 1 (Autumn, 1992)

"Employer Health Care Plan Design and Plan Cost." *Inquiry* (Spring, 1991)

"Teaching Hospital Costs: The Effects of Medical Staff Characteristics" with Richard Willke, *Health Services Research*, Vol. 25, No. 6 (February, 1991)

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REFEREED ARTICLES FOR:

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GRANT OR CONTRACT REVIEW COMMITTEES FOR:  
Small Business Administration  
National Institute of Drug Abuse

/ April 29, 1996 *Business Insurance*

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# Tennessee seizes MEWA

## Assets were skimmed, regulators say

By DOUGLAS McLEOD

**NASHVILLE, Tenn.**—Tennessee insurance regulators are now in control of a multiple employer welfare arrangement whose operators allegedly siphoned away more than \$10 million in benefit fund assets for personal purposes.

A federal judge in Nashville earlier this month froze the assets of International Assn. of Entrepreneurs of America Benefit Trust, a MEWA that has stymied regulators in nearly a dozen states for more than two years with court challenges to state regulatory authority.

The judge also appointed an independent fiduciary—Jeanne Barnes Bryant, receivership director for the Tennessee Department of Commerce and Insurance—to take over administration of the trust.

The order was sought by the U.S. Labor Department, which charged in an April 12 lawsuit that several IAEA officials and benefit plan trustees misused trust assets in acts of "gross self-dealing" that violate federal law.

Those acts included awarding themselves excessive compensation and hiring investment, accounting and travel firms they controlled to do work for the trust.

IAEA Benefit Trust hasn't been declared insolvent. However,  
*See MEWA on page 48*

# MEWA

Continued from page 2

The court has ordered Mr. Bryant to determine whether it is still viable and to recommend either a reorganization or, if necessary, liquidation.

None of the defendants could be reached for comment.

IAEA and its affiliates marketed "24-hour" workers compensation

and health insurance in at least 28 states to employers that became members of the International Assn. of Entrepreneurs of America employer group. From 1982 to 1985, IAEA collected more than \$25 million in employer contributions for the coverage.

As of last December, it had 333 employer members with about 16,000 insured employees, according to the Labor Department.

For at least two years, IAEA has bedeviled state regulators in a game of legal trench warfare, challenging state regulatory authority in a barred room of federal and state court litigation (ET, April 17, 1985).

Earlier this month, though, the federal government weighed in with a complaint filed in U.S. District Court in Nashville. In addition to the IAEA Benefit Trust itself, the lawsuit names:

- Joseph N. Fure, James E. Taylor and M. Ray Wadle, either owners or officers of both of IAEA Inc., an Irving, Texas, firm that provided management services to the trust and its employer association.

- Ross N. Fuller, a Nashville-based IAEA trustee, and Stockton Fuller & Co. Inc., an investment firm he controlled.

- Norman Rosenberg and William T. Chervonak, IAEA trustees.

- National Affiliated Adjustment Co., a Scotchdale, Ariz.-based claims adjuster for IAEA Benefit Trust, and its operators, Katherine Meyer and Norman E. Meyer.

According to the lawsuit, none of the IAEA Inc. officials or benefit plan trustees ever determined whether they were charging employees enough to support the workers' compensation and health benefits offered.

At the same time, Mr. Taylor and Mr. Fure diverted more than 30% of the contributions—of least \$1.9 million—to themselves, their families or companies they own, the government alleges.

The two men diverted the funds through IAEA Inc., which marketed the plan, collected the employer contributions and set its own compensation for those services, according to the suit.

In addition, the suit charges that:

- Mr. Fuller used the other trustees hired Stockton Fuller to provide investment advice without competing bids. Mr. Fuller set his own and Stockton Fuller's compensation, and collected about \$800,000 from November 1982 to April 1985.

- Mr. Fuller arranged more than \$1 million in unsecured or under-cured loans from IAEA Benefit Trust to friends and associates. In one case,

he loaned a friend \$720,000 to buy a motel. When the borrower failed to make payments, Mr. Fuller himself took out a loan from another institution to cover the debt, the suit says.

- Mr. Chervonak voted to hire a friend William A. Thorne, as the IAEA trust's accountant, even though Mr. Thorne was not a licensed accountant at the time. Mr. Chervonak and Mr. Thorne later set up their own accounting firm, which collected \$92,000 for IAEA services.

- Mr. Rosenberg was paid for IAEA travel services through a travel agency he owns.

- Mr. Fuller amended trust documents to allow himself to invest IAEA assets in options and margin securities trades. He lost \$480,000, the suit says.

- IAEA officials used \$1.7 million of trust assets to pay lawyers to fight state regulatory actions, payments that "were not in the interest of" fund participants.

- The trust paid an excessive \$15 million to National Affiliated Adjustment for claims services between 1982 and 1985. The company, formerly known as Realistic Adjustment Co., had been an adjuster for an allegedly bogus union welfare plan that collapsed in 1982.

IAEA itself had generated business for the purported union fund, set up by United Labor Council Local Union 615, before setting up its own self-funded MEWA.

Separately, Norman Meyer and Realistic settled with the Labor Department April 1 agreeing to pay more than \$90,000 in restitution and damages over the Local 615 collapse.

U.S. District Judge Todd J. Campbell signed a temporary restraining order April 12 freezing bank accounts and other assets of IAEA Benefit Trust, IAEA Inc. and Messrs. Taylor, Fure and Wadle.

The order specifically lists several bank and stock brokerage accounts of the defendants.

In a partial settlement, Mr. Fuller, Mr. Chervonak and Mr. Rosenberg agreed to resign their positions with IAEA and have been enjoined from dealing with benefit plans governed by federal law, the Labor Department announced. E

U.S. DEPARTMENT OF LABOR

SECRETARY OF LABOR  
WASHINGTON, D.C.

SEP 12 1995

The Honorable William F. Goodling  
Chairman  
House Committee on Economic and  
Educational Opportunities  
House of Representatives  
Washington, D.C. 20515

Dear Mr. Chairman:

I appreciate the opportunity to provide the Department of Labor's views on H.R. 995, the "ERISA Targeted Health Insurance Reform Act of 1995." As you know, the President has repeatedly declared his commitment to working with Congress on a bipartisan basis to develop incremental health reforms that put America on the road to health security, and I look forward to working with you in this regard. The President has stated that he will evaluate any health reform proposal in the context of whether it takes constructive steps toward his ultimate goal of providing every American with affordable health insurance, as outlined in his balanced budget proposal. This letter will outline, within the context of the President's goal, the Department of Labor's views on H.R. 995.

Federalization of the Regulation of Insurance

This bill would effectively federalize the regulation of all group health insurance, including policies issued by insurance companies, thereby ending the long-established role of the states over this area of insurance. This would be accomplished by setting Federal maximum limits on insurance provisions traditionally regulated by the States, such as rating variation and preexisting condition exclusions, without allowing the States any flexibility to build on these reforms. We believe that this major change from state to federal government authority in this area of insurance regulation is a major drawback of this legislation. It is particularly counterproductive to have the federal government take over this responsibility when many states have adopted higher insurance standards than those proposed by the bill.

Further, the bill would require considerable additional federal resources to enforce the substantial new responsibilities envisioned by this legislation, as the Department of Labor would replace the states as regulator of the insurers that provide private group health insurance covering tens of millions of Americans. For example, the Department of Labor would have to issue approximately 26 new regulations to establish a major

exemption program for MEWAs and would have regulatory enforcement and administrative responsibilities for solvency and participation standards. The Department simply does not have the resources to carry out the substantial new responsibilities envisioned by this legislation. This proposed increase in Federal responsibilities is troubling in an environment where Federal resources are being dramatically reduced.

We believe that with the exception of certain minimum standards regarding insurance market reform and consumer protection as outlined in the President's budget proposed in June 1995, states should have the flexibility to deal with health care, since it is the states that principally bear the burden of the high number of uninsured and the high cost of medical care.

#### Federalization of Multiple Employer Pooling Arrangements

Another Department of Labor concern is that the legislation would create new national pooling arrangements that would not be subject to state financial solvency law but would instead be subject to federal standards that are not fully developed. Generally under H.R. 995, Multiple Employer Welfare Arrangements (MEWAs) that offer only health benefits must obtain an exemption from the Department of Labor to avoid state regulation. These exempted arrangements are known as Multiple Employer Health Plans or MEHPs<sup>1</sup>. Unless the federal legislation specifies financial solvency standards equivalent to or greater than the strongest state standards for insurance companies, these new federally organized arrangements could proliferate and dominate the market as they will have a competitive advantage over insurance companies required to meet tougher state solvency standards. Having many inadequately financed pools could result in numerous entities being unable to provide benefits for their enrollees. When an insolvent pool fails there will be no state guaranty fund to assure that promised health care benefits are delivered.

These multiple employer arrangements could also skim good risks from the small group market, obviating any ability the states may retain under the bill to effectively pool risks on an equivalent basis with larger employers. The danger is that only high risk individuals will be left in the pools of state-regulated insurance companies, resulting in skyrocketing rates such individuals cannot afford and forcing state-regulated insurers to drop out of the small group health insurance market.

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<sup>1</sup> To avoid confusion between the terms "MEWA" and "MEHP" any discussions of the multiple employer health arrangements under the proposal will refer to them as "pools".

In addition, we strongly believe that state insurance authorities are better suited than the federal government to carry out the regulation of pools as they have expertise in enacting and enforcing substantive insurance laws. As the National Association of Insurance Commissioners (NAIC) testimony before the Employer-Employee Relations Subcommittee on March 28, recognizes, MEWAs function very much like insurance companies and should be regulated as such. Many states currently provide for stricter regulation of MEWAs (e.g., tougher solvency standards) than those provided under the bill.

Instead of H.R. 995's exemption procedure allowing MEWAs to be designated as MEHPs and therefore exempt from state regulation, we believe that current law should be clarified regarding the ability of the federal and state governments to protect consumers against abusive and fraudulent MEWAs. As under current law, the states should have primary responsibility for regulating MEWAs, due to the expertise of states in regulating the business of insurance. In addition, DOL should continue its traditional role of regulating fiduciary matters with respect to MEWAs. Of course, in that role, sufficient enforcement authority is critical for the Department. Like the members of the Committee, we realize that the real challenge is the elimination of abusive and fraudulent MEWAs. The Department would be happy to work with your staff to develop language clarifying the role of state and federal governments with respect to the regulation of MEWAs.

The Administration also believes that there are alternatives to the proliferation of MEWAs that will serve the goal of expanding affordable coverage for small businesses. We urge you to consider the President's proposal to provide access to plans offered through the Federal Employees Health Benefits Program (FEHBP) for small employers that lack access to purchasing pools. This would enable small firms to get coverage from plans that also provide coverage to federal employees through FEHBP, but the coverage would be separately rated in each state, leaving premiums for federal employees unaffected.

#### Consumer Protection Measures

The Department believes that health plan participants and beneficiaries need protection beyond what is provided in H.R. 995. Consideration should be given to implementing new standards of review in civil action involving benefit claims denials, establishing an alternative dispute resolution (ADR) demonstration project to resolve plan claim disputes more efficiently, and additional reporting and disclosure requirements for ERISA health plans to provide enrollees with timely notice of plan changes and other relevant information.

## The President's Proposal

The Administration's health reform package includes a bar on pre-existing condition exclusions for the previously insured, requires insurers to renew coverage for groups and individuals regardless of health status, and imposes rating limitations in the small group insurance market to limit the ability of insurers to increase premiums based on an individual's claims history. States would also have the flexibility to implement more comprehensive insurance reforms.

In any health care reform proposal, the President believes strongly that there should be a health insurance subsidy for those who have lost their insurance due to temporary unemployment. Because this issue would be under your jurisdiction, we urge you to consider the President's proposal to include provisions to assist working Americans and their families that lose their health insurance when they are laid off. People who work hard yet lose their jobs should not also have to face the burden of losing their health insurance. We urge you to consider ways to help working families retain their health insurance during temporary periods of unemployment as is the case under the proposal outlined in the President's balanced budget initiative.

## Conclusion

In summary, the federal government should pass minimum standards in health insurance and give the states flexibility to deal with the individualized needs of their populations. We oppose any attempt to set federal maximum standards, preempt all other state group health insurance standards and shift regulatory and enforcement responsibility for this area of insurance to the federal level. In addition, we believe it is important for this committee, as it considers incremental health care reform measures to keep in mind the entire health care system, including Medicaid. Although we recognize that the Committee does not have jurisdiction over Medicaid, we believe that Committee members should know that the Administration opposes the proposals before Congress to block grant the Medicaid program. An Urban Institute report estimated that the Medicaid block grant could force states to cut services and provider payments and eliminate coverage for up to 8.8 million recipients in FY 2002. By following the President's proposals a federal-state partnership would be created, giving states needed flexibility and assuring minimum standards of protection and opportunities for increased coverage and cost efficiency through market competition.

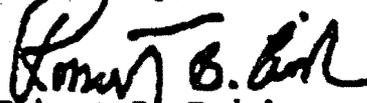
The Administration recognizes the concerns of multi-state business that they will be subject to a variety of state requirements, and we sympathize with the bill's response to these

concerns, but we cannot support the bill's top-down approach. Working through the NAIC, states are moving toward unity in insurance regulation. Governors know very well that onerous requirements on business can reduce employment opportunities.

In conclusion, we thank you again for the opportunity to comment on these matters. We look forward to providing further input on this bill and to working with you on these issues.

The Office of Management and Budget advises that there is no objection to the submission of this letter to the Congress from the standpoint of the Administration's program.

Sincerely,

A handwritten signature in dark ink, appearing to read "Robert B. Reich". The signature is stylized with a large, sweeping initial "R" and a cursive "B. Reich".

Robert B. Reich

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LENGTH: 1240 words

SECTION: HEALTH CARE & BENEFITS: ENFORCEMENT.

TITLE: LABOR SECRETARY REICH FILES LAWSUITS TO RAISE PRESSURE ON FRAUDULENT MEWAS.

TEXT:

As part of a national enforcement effort, the Labor Department filed five civil lawsuits against health insurance providers that failed to pay \$4 million in benefit claims, Labor Secretary Robert B. Reich announced March 31.

"This week the Labor Department is intensifying its crackdown on fraudulent health care schemes," Reich said at a news briefing. Civil suits filed March 30 in federal district courts in California, Mississippi, Oklahoma, Texas, and Utah, targeted illegitimate multiple employer welfare arrangements operating under the guise of employee leasing organizations or sham unions, he said. Reich was joined at the briefing by Olena Berg, assistant secretary of labor for the Pension and Welfare Benefits Administration; Labor Department Solicitor Thomas S. Williamson; and Gustave A. Schick, assistant inspector general for the department's Office of Labor Racketeering.

Across the country, fraudulent MEWAs have taken advantage of small business owners who often cannot afford the high cost of health insurance for their employees, Reich said. "Small businesses are easy prey for these kinds of rip-off artists," he said.

Unscrupulous insurance providers offer small firms access to cheaper benefits and then fold, leaving thousands of employees with unpaid claims and no health insurance benefits, Reich said. The health insurance schemes targeted in the department's lawsuits affect 27,000 workers, he said.

Tip Of An Iceberg'

Since states generally do not collect data on MEWAs, the Labor Department does not know how many people may be insured through legitimate MEWAs or fraudulent arrangements, Reich said. "We're dealing with the tip of an iceberg but we're not sure how large the iceberg is," he said.

BNA, Inc., BNA Pension & Benefits Reporter, April 4, 1994

Reich said a General Accounting Office report released in March 1992 provided the most current data on fraudulent MEWA activity (19 BPR 447). According to the GAO report, fraudulent MEWAs left at least 398,000 health plan participants with over \$123 million in unpaid claims between January 1988 and June 1991. "We have every reason to believe the problem has gotten worse since then," Reich said.

Assistant Inspector General Schick called the lawsuits "an important offensive in the continuing war against the MEWAs." Since 1989, the department's Pension and Welfare Benefits Administration and its Office of the Inspector General have initiated 75 criminal MEWA investigations which resulted in 73 indictments, 60 convictions, and \$100 million in court-ordered restitution, he said. At present, the department has 100 ongoing cases, he added.

According to the department, a MEWA is an arrangement established to offer health benefits to the employees of two or more employers. Generally, MEWAs are subject to both state and federal regulation. However, under the Employee Retirement Income Security Act, an arrangement established or maintained under a collective bargaining agreement is not considered a MEWA and therefore is exempt from state regulation.

To take advantage of this exception, some con artists have created phony labor unions which sign bogus collective bargaining agreements, the department said in a fact sheet. These arrangements then claim they are exempt from state insurance regulation.

Unscrupulous MEWA operators also seek to evade state law by claiming all participants are employees of one employee leasing organization, not of their actual employers. "In either case, avoidance of state regulation means not having to comply with . . . state solvency and reserve requirements," the department said.

#### Summary Of Lawsuits

Berg outlined the department's lawsuits, which involve three allegedly fraudulent employee leasing firms and two allegedly fraudulent unions. In all cases, the department is seeking the removal of the defendants as health care trustees, the restitution of funds, and repayment of any illegal compensation, she said. The department also is seeking to bar the defendants from serving as trustees for any ERISA-covered plans in the future, she added.

Berg said the lawsuits are:

-- Reich v. Houck -- filed in Dallas, involving more than \$1 million in unpaid claims. The department sued Dallas-based Employee Staffing Services Inc. and three other employee leasing firms created by Charles Michael Houck, which

BNA, Inc., BNA Pension & Benefits Reporter, April 4, 1994

at their peak covered nearly 20,000 participants. PWBA alleged that ESSI and its affiliates were fraudulent firms designed to market medical benefits to small employers, and that the defendants improperly mismanaged plan money:

-- Reich v. Phillips -- filed in Salt Lake City, Utah, involving more than \$400,000 in unpaid claims covering 700 workers and dependents. The department sued Americor Employer Support Services, a Salt Lake City employee leasing firm, and its owner, Errol L. Phillips. The department charged that Americor was a fraudulent firm whose owner used plan contributions to pay personal expenses;

-- Reich v. Van Devender -- filed in Jackson, Miss., involving more than \$785,000 in unpaid claims covering more than 600 participants. The department sued Mississippi-based Job Mate Affiliated Companies Inc., created by Charles Harold Van Devender and his wife Georgia as an employee leasing firm to market health care benefits. PWBA said Job Mate was a fraudulent MEWA operating in eight states and charged the defendants with mismanaging plan money;

-- Reich v. Newsom -- filed in Oklahoma City, involving more than \$1.3 million in unpaid claims and 5,000 plan participants. The department obtained a temporary restraining order, freezing the assets of a multi-state health and benefit plan sponsored by Contract Services Union Local 211, based in Oklahoma. PWBA charged that Local 211 was a sham union set up to market health benefits; and,

-- Reich v. American Healthcare Underwriting Managers -- filed in Los Angeles, involving more than \$605,000 in unpaid claims from more than 3,000 participants. The department sued principals affiliated with the National Council of Allied Employees International Union Local 555 in Encino, Calif. PWBA said Local 555 was a sham union that had only about \$40,000 to cover almost \$605,000 in unpaid claims when it ceased operations in 1992.

#### Increasing Awareness

By publicizing its most recent MEWA cases, Reich said the department hoped to increase awareness among small employers about the dangers of fraudulent health insurance arrangements. "The combination of an informed public and a commitment . . . to prosecuting wrongdoers is probably the best remedy" to the MEWA problem, he said.

"Hopefully, national health insurance will resolve the problem," Reich added. Berg said that, under President Clinton's health care plan (HR 3600/S 1757), MEWAs would have no opportunities to operate.

Reich offered some suggestions to help small employers recognize fraudulent unions and fake employee leasing firms that offer health care benefits.

Employers should make sure the collective bargaining agreement offered by the union covers typical labor/management issues, such as salary, and that the union does not exist solely to offer health care benefits.

Legitimate employee leasing firms should have control over their employees, Reich said. Employers should ask for the firm's audited financial information. Employers also should make sure the firm's funds are segregated and earmarked to pay benefits and that premium rates are determined by an actuary.

LANGUAGE: ENGLISH

In recent years, small firms that have had difficulty purchasing employee health coverage have turned to multiple employer welfare arrangements, or MEWAs, to gain access to health coverage on terms similar to those available to large firms. As part of a larger study on employee health benefits, researchers at RAND Corporation conducted a study examining various aspects of MEWAs. Their efforts culminated in a report that characterizes the different types of entities that operate as MEWAs, defines the climate in which MEWAs flourish, describes how MEWAs operate, and offers conclusions for policy implications. This Research Report is an edited version of the report, which was authored by Arleen Leibowitz, Cheryl Damberg, and Kathleen Eyre.

The MEWA study is one of 15 employee health benefits studies conducted by the RAND Corporation and the Urban Institute under a contract with the Department of Labor's Pension and Welfare Benefits Administration. The reports have been published in a volume entitled "*Health Benefits and the Workforce*," which is available for \$14 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, telephone (202) 783-3238. The stock number is 029-000-00442-1.

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As MEWAs have grown in number and popularity, they have been increasingly in the news due to abusive business practices, resulting in insolvencies that have left employers and employees liable for millions of dollars in unpaid health claims. These insolvencies have hit employers and employees particularly hard because policyholders under MEWAs may not have access to state insurance guarantee funds to cover unpaid claims.

### **Multiple Employer Trusts**

ERISA's definition of "multiple employer welfare arrangement" encompasses all types of insurance-like arrangements that involve more than one employer, regardless of their corporate structure, insurance status, or status as an "employee welfare benefit arrangement" subject to ERISA. With a few specific exceptions, such as collectively bargained arrangements, these entities remain exempt from state regulation.

One exception to this rule is MEWAs that are sponsored by insurance companies. These arrangements are often organized as trusts, and as such are referred to by insurers as (multiple employer trusts) METs. The Department of Labor has determined that unless there is a relationship other than purchasing health coverage among the employer-participants in the trust, the MET is not subject to ERISA (DOL Advisory Opinion No. 81-73A).

Insurers are careful to distinguish their MET product from MEWAs, which they consider to be very different and acting outside any type of insurance regulation. The

segregation is undoubtedly due to the large number of MEWAs that have become insolvent, a situation that threatens to affect the regulation of all multiple employer plans.

The primary distinction between insurance company METs and MEWAs is that METs are marketed as fully insured products by insurers who are authorized to sell insurance in the states in which they operate. Consequently, these plans must comply with state insurance regulations concerning their financial solvency, such as having to post a bond to do business, setting aside reserves, and paying premium taxes to state guarantee funds.

METs also have direct trustee oversight of the insurance plan to ensure that funds are appropriately managed. The long-term viability of the firm is the major concern of plan operators. For instance, all insurance company METs investigated during the RAND study performed medical underwriting for their small group product and did not guarantee coverage to any group. Many stated that they were unwilling to accept certain industry groups, such as mining, construction, medical groups, hair salons, florists, and lawyers, because these groups pose an "unacceptable risk."

By underwriting the groups that the MET agrees to accept, insurers are able to base the premiums on actuarial principles designed to protect their profits and solvency. Because insurance-company-sponsored METs operate virtually identically to individual and large group insured health plans, they are usually more expensive than the other types of MEWA plans discussed below, and they tend to be more financially stable.

### **Association Plans**

Business associations sponsor health plans that may be either fully insured or self-insured. Some insurers or third party administrators (TPAs) may claim to represent an "association," though they simply establish a plan and then market it to individual employers that may or may not fall into a particular industry or professional grouping. The different types of MEWAs that legitimately and illegitimately use the "association plan" title are described below.

*Fully Insured, "Bona Fide Association" Plans.* Many long-standing groups, formed for purposes other than providing insurance, sponsor health insurance plans. These plans often are underwritten by insurance

companies, which use standard insurance practices to decide whether to cover particular individuals and which may or may not pool all association members together for rating purposes. Some insurers reported that association rates may be slightly lower than their rates for standard MET plans or individual policy prices, but other carriers stated the opposite. For these insurers, their association business has matured and their rates have become expensive compared to rates for other insured groups in their pools. "Bona fide" associations may have greater incentives to monitor their plans to assure the best value and service for members, as well as to assure that the organization's name is not affiliated with financially questionable operations.

Insurers said that they saw administrative efficiencies in offering association-sponsored plans, particularly the ease of marketing the product as part of association membership. Some insurers, however, expressed serious doubts about the continued viability of association-sponsored plans. Membership in association plans tends not to be guaranteed or stable, and it often peaks after a certain amount of time. Without the influx of new members, the groups' risk profile tends to deteriorate, which forces premium increases. Furthermore, because 100% participation in the health plan by association members is not required, individuals are free to move in and out of the plan at their choosing. The price sensitivity of small employers causes many individual employer members to switch plans frequently in search of better pricing when premiums rise. The turnover of firm members in the association plan typically results in a highly unpredictable group.

Also, for those association MEWAs that pay claims out of cash flow, the inability to continually attract new members can force the plan to become insolvent once the lag in the submission of claims for payment catches up with the collection of premiums.

*Self-Insured, "Bona Fide Association" Plans.* The success of self-insured association plans appears to depend to a great degree on the regulatory environment in which they function. In Michigan, about 20 association-sponsored plans have succeeded because they are held to financial standards similar to those of insurance companies. Also, the TPAs that manage these plans appear to set appropriate rates and engage in medical underwriting, yet still offer a competitively priced, viable health coverage alternative for small business members of associations.

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Legitimate associations that sponsored self-insured plans without adequate management, including the failure to reserve, to rate realistically, or to seek stop-loss coverage, have failed. For example, a plan sponsored by an association of schools in Texas decided to self-insure and hired consultants to assist the association with establishing a self-funded plan. The consultants apparently failed to provide adequate advice, and suggested that the association need not contract for stop-loss coverage. Within two years, the claims lag caught up with the association, and it is now entangled in litigation resulting from the insolvency.

*Insurer-Created "Pseudo-Associations."* In some instances, entrepreneurs, in conjunction with small insurers, may create organizations that claim to represent an interest group, allegedly for purposes other than seeking insurance. TPAs will create the group, market it, and then seek health insurance coverage from a small insurer in need of quick cash flow. Often these small insurers are not financially sound themselves. These "pseudo-association" plans then seek the "group" label to avoid more stringent state regulation of individual plans and to enjoy reciprocity offered by some states to other states' "group" designations.

Regulators that were interviewed for the RAND study believed these types of plans were inherently less stable than standard groups. Pseudo-association leadership does not provide the protective oversight as in the case of bona fide associations to assure that members are not exploited or that the sponsor is not mismanaging the plan funds. This is particularly true with respect to overseeing the quality of the insurer backing the plan. Several states have recently instituted policies or passed legislation to screen any plan claiming to be an "association" in an effort to assure that the organization is bona fide.

### **Good Faith Versus Exploitation**

The study found that some TPA-initiated multiple employer welfare plans do not seek insurance coverage at all, or continue to sell health plans after their insurers dropped coverage or became insolvent. As a result, these types of MEWAs function in a self-insured fashion and bear full responsibility for the risks, facts often unknown to the plan members. These arrangements

may attempt to legitimize themselves with an association label or falsely advertise that they are insured when, in fact, they merely maintain an administrative services only (ASO) contract with an insurer.

Self-funded MEWAs tend to guarantee coverage to any firm that wants to purchase coverage. They typically set very low premiums, sometimes up to 40% below comparable insured small group plans. Many of these plans fail to engage in formal reserving and claim to rely on stop-loss coverage to pay claims that exceed premiums. However, the stop-loss coverage usually becomes available only after the amount paid on an individual claim or on all claims in the aggregate exceeds a certain amount (the "attachment point"). Insolvent MEWAs generally are unable to pay the claims that would activate the stop-loss insurance.

Increasingly, self-funded MEWAs are marketing their plans directly to small employers, in lieu of marketing through brokers and agents, who may be better informed about the questionable financial status of these plans. For example, one agent reported that a plan gave itself an industry name such as the Flowergrowers Health Plan, purchased a mailing list for all companies within that industry, and then approached the companies directly, claiming to have a tailor-made product.

Because these MEWAs do not set aside reserves, they must pay claims out of incoming premiums on a cash flow basis. This strategy works only if enrollment in the plan continually increases, which is rare. Because of the delay in receiving and processing health care claims, such MEWAs are able to flourish for a period of time. One regulator said that it may take 12 to 18 months for the claims tail to catch up. Eventually, the MEWA starts to slow its claims payment, fails to pay large claims altogether, and then either declares bankruptcy, or quietly slips out of the state.

Although regulators stated that some of these MEWAs are simply naively mismanaged, others are conceived to exploit the public and reap short-term personal rewards.

### **Associate Union Memberships**

Union-sponsored health plans, which open enrollment to nonunion individuals, may operate like MEWAs by providing health coverage to multiple em-

employers, often in a self-insured manner. These types of health plans claim preemption from state insurance regulation because they operate as collectively bargained plans under ERISA and the Taft-Hartley Act, and not as MEWAs. Furthermore, the federal regulations that apply to these self-funded plans under ERISA relate to plan structure, and not to funding standards designed to protect the solvency of the plan. Because state and federal governments exercise only minimal oversight over these plans, insurance regulators fear the potential for the same abuses observed with MEWAs.

State insurance regulators are concerned that these plans function as insurers in an unregulated manner and closely resemble MEWAs in their structure and operation. Virtually all of these entities are self-insured or partially self-insured trusts, and it is unclear whether they set aside sufficient reserves to prevent insolvencies that can result from large claims. Regulators also question whether a collectively bargained plan preemption is warranted when a union opens its doors to market insurance products to nonunion employee groups.

Associate union memberships occur when union plans solicit members among employees of small companies, who are given the opportunity to join the union for the purpose of gaining access to the union's health benefits program and other assorted union-sponsored services, such as dental insurance, credit unions, and mail-order pharmaceuticals. The associate members pay dues to the unions in order to participate in these services, but are not part of the union's bargaining unit.

Associate union members provide a critical source of revenue to the union. For example, the Mail Handlers Union, which has about 50,000 full-time members, has nearly 500,000 associate members who subscribe to its health plan and pay dues. The International Ladies' Garment Workers' Union also uses associate memberships, with annual fees averaging between \$30 and \$50. Unions also see associate memberships as a good method to sell the advantages of unionization in an era of dwindling union membership, and employers may view associate union memberships as a way to fend off true unionization of their work force while gaining access to health insurance at more attractive rates.

It is not known how many unions offer associate memberships. The total number of associate members was estimated at 300,000 as of April 1989.

### **Employee Leasing-Firms**

Health plan organizers sometimes used employee leasing firms to avoid state regulation. These firms nominally hire the employees of many firms and then lease them back to the individual employers on a contract basis. Leasing firms can offer significant cost benefits to employers by pooling large numbers of employees from different businesses to provide services. Some firms that market this service agree to handle certain administrative functions, and often agree to provide benefits to the leased employees. Other firms, however, engage in practices that are intended only to avoid state insurance regulation by setting up self-funded health plans for multiple employers.

In 1983, fewer than 4,000 employees were leased. The current number of leased employees is estimated to be between 1.5 million and 2 million and is projected to grow to 10 million by the year 2000. The National Staff Leasing Association (NSLA) estimates that currently there may be as many as 1,500 leasing firms. Of the total, only 183 belong to the national association. The NSLA is seeking to move the industry toward self-regulation, because of a number of health plan insolvencies that threaten the existence of well-managed leasing firms.

Until 1988, most leasing firms offering health coverage were fully insured, according to an industry spokesperson. Then, in response to large losses faced by many insurers, premiums increased by 30% to 40%, making the insurance less affordable and causing many firms to switch to self-funding. Between 60% and 70% of all leasing firms currently self-insure their health benefits packages. Because they are the nominal employer, they seek preemption from state regulation as a single-employer plan under ERISA, and claim to be exempt from state health insurance regulations, such as reserve requirements and benefit mandate laws. Often, these plans lack adequate reserves or do not charge sufficient premiums to assure their solvency in the long run. Leasing firm plans that have become insolvent include ATS, American Workforce, CAP Staffing, Criterion, and Synesys.

Leasing firms are heavily concentrated in Florida, Texas, Oklahoma, South Carolina, New York, New Jersey, and California, perhaps due to the large concentration of small businesses in these states. A major impetus for their creation is to obtain low cost workers'

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compensation insurance. Leasing firms can secure lower rates for workers' compensation by claiming to be a new firm without any prior claims experience against which to rate, or periodically changing the name of the leasing firm, leaving no claims trail for an insurer to check.

Although many leasing firms practice sound business principles, regulators have identified major problems with some leasing firms. These include defrauding the workers' compensation system; defrauding state assigned risk pools; and acting as unauthorized insurance operations, which pose considerable risk for insolvency. Regulators in several southern states have expressed concern about them, given that the states' authority to regulate these firms is unclear.

The insolvency of CAP Staffing demonstrates the problems associated with MEWA-like plans offered by leasing firms. CAP Staffing was federally indicted in 1989 for selling phony employee health insurance and other benefits to more than 120 employers in eight states. Over a five-year period, the plan bilked customers out of millions of dollars in premium payments and left more than 13,000 workers and families without health care coverage. CAP Staffing claimed its health plan was insured by Travelers, when it was actually self-insured.

Investigators determined that CAP Staffing became insolvent because it charged premiums well below what was required to cover claims expenses based on actuarial calculations. There are obvious similarities to many MEWA plans, since CAP Staffing was self-insured and did not set aside reserves, priced below what was actuarially sound, falsely advertised to be fully insured, guaranteed issue, and operated outside the purview of state insurance regulation by claiming to be a single employer.

#### **How Many MEWAs Exist?**

The study found that there is no reliable estimate as to the number of MEWAs that exist. The study cites a 1991 published estimate that put the number as "at least 3,000," but stated that this number is impossible to verify. It is difficult to estimate the number of MEWAs because most operate as unlicensed insurers, hoping not to be found or counted by federal or state regulatory authorities. There is a belief, however, that the MEWAs

that have come to public attention as the result of criminal behavior are only a small percentage of existing MEWAs.

As part of the study, state insurance commissioners were asked to estimate the total number of MEWAs operating in their state. Some states could not provide an estimate. In other states, the conductors of the study felt that the estimate might be low because they did not have a good mechanism for obtaining information about MEWAs until an insolvency occurred. Similarly, the purchasers of health insurance policies cannot be relied on to accurately report that they have their coverage through a MEWA, as buyers of MEWA plans are often unaware of the distinction between a MEWA and conventional insurance.

Calculations from a survey conducted by the Health Insurance Association of America showed that 10% of the small firms they surveyed reported that they were insured through a "multiple employer trust." It is difficult to translate this number into an estimate of MEWAs because conventional insurance companies often place their small group business into METs, as described above. Also, other arrangements, such as associate union memberships and employee leasing firms, behave in ways similar to MEWAs. Thus, a count of MEWAs alone would not provide a complete assessment of the scope of problems associated with these types of health insurance arrangements.

#### **Federal Regulation**

With certain specific exceptions, "employee welfare benefits plans" covered by ERISA include those established by an "employer" to provide medical benefits, "through the purchase of insurance or otherwise." "Employer" is defined to include an individual employer and "a group or association of employers acting for an employer." A group or association of employers can establish a single ERISA-covered plan where the group or association can demonstrate that it is a "bona fide" group or association.

The DOL has indicated that this status is demonstrated by examining, among other things, who actually controls the association, who actually controls the benefit program, when and why the association was formed, and what relationship existed among members before

## An Analysis Of Multiple Employer Welfare Arrangements: Types Of Entities, How They Operate And Are Regulated

the plan began. Where several unrelated employers merely execute a trust document as a means to fund benefits and where no genuine organizational relationship exists among the employers, no bona fide group or association of employers will be deemed to exist for purposes of creating an employee welfare benefit plan (DOL Advisory Opinion No. 89-13).

Under ERISA's deemer clause (see RR 606.-1), welfare benefit plans covered by ERISA are generally outside the reach of state insurance regulation if they are self-insured. In the late 1970s and early 1980s, several well-publicized insolvencies of self-insured METs caused Congress to reconsider the issue of preemption. These METs claimed to be "employer associations" sponsoring employee welfare plans and refused to submit to state insurance regulation, such as certificates of authority, reserve standards, mandated benefits, and premium tax laws. State regulators felt that the language of ERISA appeared to protect these entities. However, ERISA does not require employee welfare plans to file for preapproval, nor does it set funding requirements for welfare benefit plans as it does for pension plans.

In an attempt to remedy this problem, Congress amended ERISA in 1983. Under the amendment, a MEWA was defined as "an employee welfare benefit plan or any other arrangement offering any benefit to the employees of two or more employers." Fully insured MEWAs (those in which all benefits are guaranteed under a contract of insurance) must comply only with state laws concerning reserve and contribution requirements. All other MEWAs must comply with reserve and contribution requirements and any other insurance regulation not inconsistent with ERISA (that is, states may not reduce or modify the fiduciary or reporting requirements imposed by ERISA).

The amendment also provided that the DOL was free to issue regulations concerning how non-fully insured MEWAs might seek an administrative exemption. To date, the DOL has not issued such regulations. However, the DOL has provided opinion letters on various ERISA provisions, including letters on the applicability of state regulation to particular MEWAs. The DOL has consistently stated that MEWAs are subject to at least some state oversight.

Accordingly, MEWAs that are also employee welfare benefit plans must meet all of the requirements of ERISA along with any insurance requirements a state wishes to impose, to the extent permitted by the MEWA provisions of ERISA. As a practical matter, however,

most states do not regulate fully insured MEWAs except to the extent the underwriting insurer must comply with appropriate insurance laws. Many states claim that when uninsured MEWAs market contracts for employee medical benefits, they are engaging in insurance-company-conduct that should be subject to state regulation of solvency and consumer protection laws.

### Interpretations Of ERISA

Even though language in the 1983 amendments to ERISA subjects all MEWAs to state regulation of some sort, sponsors of uninsured MEWAs continue to claim preemption of insurance laws by ERISA. One state insurance official said that a MEWA's typical response when investigated by the state insurance department was to claim to represent a "bona fide employer association," and because ERISA defines "employer" to include "employer associations," the entity claims to represent a single employer under this definition, as opposed to "two or more employers" under the definition of MEWAs set out in the amendment. Thus, the MEWA claims not to be a MEWA at all, but a single-employer welfare plan exempt from state regulation. State departments of insurance often must challenge other interpretations, such as MEWA sponsors claiming to be collectively bargained plans, through expensive and time-consuming litigation.

### State Regulation

Telephone interviews were conducted with officials in 18 state departments of insurance<sup>1</sup> in order to discover the approaches states use to deal with MEWAs. As one might predict, strategies vary widely among the states, from virtually no regulation, to imposing only registration requirements, to complete preapproval, financial standards, and monitoring. Several states said that MEWA laws were pending or proposed in the state legislature.

The study found that the extent of MEWA regulation did not necessarily correlate with the level of success in preventing insolvencies. It also appeared that market factors may be as strong an influence as a particular

<sup>1</sup> The 18 states were California, Connecticut, Delaware, Florida, Georgia, Illinois, Michigan, Massachusetts, Missouri, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Texas, Utah, Virginia, and Washington.

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state's approach to regulation with regard to areas where MEWA promoters choose to locate or avoid. For example, states that have a large number of nonunionized small businesses with limited affordable insurance options appear attractive to MEWAs. Patterns of regulation that emerged from the telephone interviews are described below.

### **NAIC's Act**

In 1982, the National Association of Insurance Commissioners (NAIC) developed a model act entitled "The Jurisdiction to Determine Jurisdiction of Providers of Health Care Benefits Act." In essence, the model act states that all health care benefits providers are presumed to be subject to state insurance department jurisdiction unless they provide the department with proof that another government agency permits or qualifies it to provide those services. Any other claim of preemption will fail. About 25 states have adopted this provision or some similar law.

Regulators in states that use the NAIC act to attack uninsured MEWAs as "unauthorized insurance" point to its limitation: these entities claim to be exempt from all insurance regulation under ERISA, despite the "presumption" language in the act. These entities do not voluntarily approach state insurance departments, but are only identified when policyholders complain that the MEWA fails to pay claims, or when agents call with concerns about low rate quotes. In other words, the act is not very effective.

### **Comprehensive Legislation**

Florida, Michigan, and Virginia have passed comprehensive laws intended to monitor and manage uninsured MEWAs. Each has had a markedly different experience under these laws.

*Michigan.* Michigan passed comprehensive MEWA regulations in 1986, in response to a large local insolvency in the early 1980s. Michigan's law imposes requirements on uninsured MEWAs that mirror those placed on insurance companies, and also adds several new provisions unique to MEWAs; it applies to both domestic MEWAs and those "soliciting an employer domiciled in Michigan." Michigan has not experienced

a domestic MEWA insolvency since the law was passed in 1986.

Under the law, uninsured MEWAs must apply for a certificate of authority, post bond, and demonstrate financial viability before they can solicit business. MEWAs must be sponsored by a nonprofit association of employers or employees that has existed for at least two years with some purpose other than the provision of insurance to members. An association must consist of at least five members with a total of 200 policyholders and annual gross premiums of at least \$200,000.

Other provisions in the law prevent conflicts of interest by employer trustees, assure adequate internal administration or (as is the case for most Michigan MEWAs) a contract with a TPA, and require annual reports and examinations to assure continuing financial viability. Stop-loss insurance is required at a \$25,000-per-occurrence basis; aggregate stop-loss insurance is optional. Michigan regulators believe that stop-loss limits, which can be upward of \$1 million, are often useless because most MEWAs will be bankrupt before the limit is met.

Reserve and surplus standards are also specified: the greater of 25% of aggregate premium contributions for the current fiscal year or 35% of paid claims in the year. Reserves may not fall below 2-1/2 months of yearly premiums or the MEWA must assess its policyholders an extra month's premium. Only about 20 MEWAs are regulated, because a large percentage of Michigan's population is unionized and covered through collectively bargained plans.

*Florida.* Florida has had less success in assuring solvency of its licensed, uninsured MEWAs. At the time the study was conducted, only five of the 28 plans that Florida had approved under its law remained functioning, and three of those were running deficits. All the other plans became insolvent and voluntarily dissolved, or were forced into receivership by the state.

Some of Florida's standards parallel Michigan's, including allowing only bona fide nonprofit associations to sponsor MEWAs. However, Florida's law differs from Michigan's in several ways. Most significantly, until recently, the law did not set specific reserve and rate guidelines for MEWAs to follow. Instead, the law pro-

## An Analysis Of Multiple Employer Welfare Arrangements: Types Of Entities, How They Operate And Are Regulated

vided that MEWAs seek actuarial guidance in setting reserves, in pricing the product, and in determining stop-loss coverage. Florida recently changed its law to allow for assessments of MEWAs to fund claims for those that become insolvent and also to set reserve standards.

The reasons listed by the interviewee for the large number of uninsured MEWA failures in his state include poor rating practices, inadequate or nonexistent capitalization, lack of underwriting, poor financial and claims management, and poor reporting.

Florida was often named as the site of troublesome MEWAs that market in other states—uninsured MEWAs that had not bothered to become licensed under Florida's laws. Regulators in Florida have investigated seven of these MEWAs, as well as eight associate union plans, and estimate that as many as 80-100 self-funded employee leasing firms exist there. When trying to understand the source of Florida's reputation for harboring many uninsured MEWAs, it is difficult to sort out the effects of demographics from those of the weak MEWA licensing law, especially because so many MEWAs simply claim preemption from the regulatory procedure to begin with.

**Virginia.** Regulations in Virginia require that all MEWAs apply for state licensure before marketing health coverage in the state. Licensure requirements include a security deposit, maintenance of a defined minimum surplus and the same level of reserves insurers must maintain, and the establishment of "risk-sharing" agreements. The regulations apply to all MEWAs, but also contain a provision that allows fully insured MEWAs to apply for preemption from the statute if they demonstrate their fully insured status (Virginia regulates fully insured MEWAs only to the extent that the underlying insurance company is regulated, which is typical of most states).

Virginia regulators have been inundated with applications for preemption—550 at last count. Regulators explained that this high number may be a result of the large number of trade associations headquartered in the Washington, D.C., area that sponsor fully insured health plans for members. Only three plans attempted to get licensed, and all three failed. Two failed to meet the stringent financial standards, and one out-of-state plan would violate its charter to market in Virginia. There was a general sense that most uninsured MEWAs could not meet the stringent financial standards imposed by the law. It is believed that most uninsured MEWAs have remained "underground."

### State Registration Laws

Several states require all MEWAs to register before they can market in that state. Their success has been mixed. In North Carolina, for example, the law required registration by all MEWAs within 60 days of passage in August 1990. At the time of the RAND study, no MEWAs had registered. In general, regulators state that fully insured MEWAs comply with the requirements, but that uninsured MEWAs continue to claim ERISA preemption even from simple registration requirements.

### Brokers Who Sell MEWA Products

Several states have used their licensing authority over insurance agents and brokers to prevent the marketing of uninsured MEWAs. For example, Utah may revoke the license of or impose fines on a broker found to be selling uninsured MEWA products. Utah and several other states issue bulletins to agents reminding them of their liability under state law for unpaid claims when they sell "unauthorized insurance" that becomes insolvent, and regulators have received tips leading to investigations of uninsured MEWAs resulting from this publicity. In order to get around these laws, however, some MEWAs are simply approaching clients directly, eliminating the agents and brokers. As a result, disciplining agents and brokers will have no effect.

### Unauthorized Insurance

Without special legislation aimed at regulating uninsured MEWAs, state insurance department officials attack them under state laws prohibiting the sale of "unauthorized insurance" (companies selling products that indemnify for health benefits but that have not sought to meet state requirements necessary before a certificate of authority is issued). Of course, some MEWA operators either ignore this position or believe that somehow they are exempt from ERISA; and without prior identification, officials cannot attack these entities until they receive complaints about nonpayment of claims or questions from agents concerned about underpriced products.

### Targeting "Pseudo-Associations"

Most states have not passed special laws regulating fully insured MEWAs, rationalizing that the insurance company that underwrites the MEWA must meet the capital, reserve, guarantee fund contribution, and other

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laws imposed on them to do business in their states. This rationale fails to consider the problems that arise when a MEWA creates a pseudo-association for marketing purposes only.

Some states are taking steps to address this type of problem with special legislation. Only "bona fide" MEWAs may market in Oregon. An association is bona fide only where active employer oversight exists to prevent abuse and where the association was not created solely to get insurance. Trust arrangements must cover one or more employers or unions in the same industry, to assure that some kind of predictability and risk-spreading occurs. The law applies to both domestic and out-of-state insurers. The state looks with suspicion at plans in which the trustee, administrator, and marketing agent are all the same or related individuals or entities rather than the employer or association. As of late 1990, 75 insured association plans had registered with the department.

#### **Regulation Of TPAs**

Several states have passed, or are planning to propose, legislation regulating TPAs. Some regulators believe that TPAs administer most MEWA business, though opinions differed as to whether most of these MEWAs were poorly run. The TPA regulations in Illinois, for example, impose requirements that include reporting on MEWA and association business, separate accounting for each client, reserving and financial standards, and conflict of interest prohibitions.

#### **Policy Implications**

MEWAs have developed as a response to small firms' demand for health coverage at affordable prices. By claiming preemption from state regulation, MEWAs can provide health coverage at a lower price. However, they expose their participants to significant financial risk as a consequence of this lack of state regulation.

MEWAs have sought to emulate self-funded employers in order to bring lower-cost health coverage products to the market. However, the RAND study's findings suggest that the analogy is not exact. Many small groups cannot be combined to exactly duplicate the situation in a single large firm. The ability of small firms to opt in

and out of the MEWA makes it inherently subject to risk selection that compromises the stability of the MEWA. Furthermore, a MEWA has no other assets to draw upon if claims exceed reserves.

The avoidance of state reserve requirements and premium taxes has been a major factor in MEWAs' ability to charge lower prices. As a result, MEWA insurance buyers are not protected from financial loss, and they assume more risk because the safety features built into state regulation are missing for MEWA policies.

It seems that many small firms do not understand that they are bearing additional risk when they purchase a MEWA product, and some MEWAs deliberately misrepresent the insurance status of their policies. However, it appears that simply notifying potential consumers that they are buying a self-funded product is not sufficient. North Carolina, which has this regulation, has been the site of notable MEWA failures.

The results of the study raised a question of whether uninsured MEWAs can be viable in any circumstances. State experience suggests that registration and disclosure of uninsured status do not provide sufficient protection. The experience in Michigan suggests that when MEWAs are regulated in a manner similar to conventional insurance, they can provide a financially stable, lower-cost source of health coverage. Unfortunately, since MEWAs do engage in jurisdiction shopping, unscrupulous operators may simply avoid stringent reserve requirements by moving their operations to another state.

The observation that MEWAs are stable when they are treated like conventional insurance companies is a two-way observation. One cost-saving feature of MEWAs is their ability to sell coverage that does not cover all the benefits mandated by state law. Consumers have demonstrated a need and a desire for this type of coverage.

In conclusion, requiring MEWAs to operate under constraints similar to those faced by conventional insurance companies and eliminating state mandates for state-regulated insurers are two alternatives for providing the small firm health care consumer with affordable coverage. ☐

## SENT TO ALL MEMBERS OF THE HOUSE OF REPRESENTATIVES

May 3, 1996

Neil Abercrombie  
United States House of Representatives  
Washington, DC 20515-1101

Dear Congressman Abercrombie:

The undersigned organizations, representing a diverse group of providers, consumers, employers and insurers, have joined together to communicate our common views on H.R. 3103, the Health Coverage Availability and Affordability Act of 1996. We urge you to contact the Members appointed as conferees and request that they:

- Support the group portability provisions in H.R. 3103; and
- Oppose the provision in H.R. 3103 that would exempt multiple employer welfare arrangements (MEWAs) -- a type of employer purchasing pool -- from state regulation and would rely solely on a new federal licensing and regulating structure for MEWAs.

We strongly support portability from one employer health plan to another. The provision would alleviate "job-lock" for as many as 23 million individuals.

We are deeply concerned, however, about the House language that would preempt MEWAs from state regulation. We believe that Congress has not adequately considered this complicated and technical issue or the serious unintended consequences that would occur if the approach became law.

The unintended consequences of passing such a law would include:

- **Preemption of state consumer protection laws** such as reserve requirements to guard against bankruptcy, premium rate limitations, minimum benefit packages and consumer grievance procedures. This is especially troublesome given the history of financial problems and fraudulent practices with many MEWAs -- the General Accounting Office (GAO) has identified hundreds of millions of dollars in unpaid claims by MEWAs that have left hundreds of thousands of subscribers stranded.
- **Destruction of the integrity of small group reforms** by allowing MEWAs to cherry pick the healthiest subscribers -- leaving the remainder of the insurance market with higher premiums. State small group reforms intended to assure affordable and adequate coverage for all small groups would be totally undermined.

Once again, we are concerned about the grave consequences of exemption of MEWAs from state regulation and ask you to oppose this provision in the conference agreement.

Sincerely,

AIDS Action Council  
American Association of Nurse Anesthetists  
American Chiropractic Association  
American College of Nurse-Midwives  
American Counseling Association  
American Federation of Home Health Agencies  
American Occupational Therapy Association  
American Optometric Association  
American Physical Therapy Association  
American Podiatric Medical Association  
American Psychological Association  
American Speech-Language-Hearing Association  
Atlanta Health Care Alliance  
Blue Cross and Blue Shield Association  
Citizen Action  
Health Insurance Association of America  
Independent Insurance Agents of America  
Justice for All  
National Association of Childbearing Centers  
National Association of Health Underwriters  
National Association of Retail Druggists  
National Association of Social Workers  
National Community Mental Healthcare Council  
National Multiple Sclerosis Society  
Neighbor to Neighbor  
Opticians Association of America  
United Church of Christ, Office for Church in Society

**NATIONAL  
GOVERNORS  
ASSOCIATION**

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Executive Director

Bob Miller  
Governor of Nevada  
Vice Chairman

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Telephone (202) 624-5300

May 13, 1996

The Honorable Robert Dole  
Senate Majority Leader  
United States Senate  
S-230 Capitol Building  
Washington, DC 20510

Also sent to:  
Speaker Gingrich  
Senator Daschle  
Congressman Gephardt

Dear Senator Dole:

On behalf of the nation's Governors, we would like to offer our comments as you begin your efforts to reconcile the Health Insurance Reform Act of 1995 (S. 1028) with the Health Coverage Availability and Affordability Act of 1996 (H.R. 3103). We believe that your efforts to reform the private health coverage market are an important first step and you are to be commended for your actions. We would, however, like to share with you our concerns in a number of areas that should be addressed by the conference committee.

***Group to Individual Portability.*** Both the House and the Senate bills contain provisions that are designed to improve portability in the group to individual market. Addressing the needs of persons in the individual and small group market is essential if we are ever to improve access to affordable health care. Both the House and the Senate are to be commended for addressing this difficult issue. The single largest concern is the potential for risk segmentation in the market and both bills are likely to lessen the problem. However, we are concerned that there is a greater opportunity for risk segmentation in the House bill than in the Senate. The House language calls for guaranteed issue of a benefits package whose value is not less than the "weighted actuarial value" of other packages in the market or offered by the same insurer. We believe that this could give insurers and health plans the ability to create packages that might segment the market by virtue of the benefits offered. In short, we prefer the Senate language for this provision.

Both the House and the Senate language allow states to develop their own portability mechanisms in lieu of the federal standards. In both cases, the Secretary of the U.S. Department of Health and Human Services has discretion in approving those alternative methodologies. In the House language, for example, a state alternative to the federal standard must demonstrate that it is "reasonably designed" to meet the goals of guaranteeing that a "qualifying individual" is able to obtain "qualifying coverage" that complies with the bills requirements relating to preexisting condition limitations. However, there is no clear guidance for the Secretary on this point nor clear criteria that would be used to determine if the state meets this test. As S. 1028 moved toward the floor last month, we were able to work with Senators Kassebaum and Kennedy to assure that their bill contained safe harbors which permitted automatic approval of certain state alternatives and limited Secretarial discretion in this area. The authority of the Secretary must be clear and restricted. We believe that neither of us is interested in a complicated regulatory process that could result in protracted litigation in order for states to be creative in this area. In short, the Senate language must serve as a guide during conference.

H.R.3103/S.1028 Conference

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***MEWAs and VHIA's.*** We agree that there is a need to place further regulations on MEWAs and agree that there is a need to expand opportunities for small businesses to purchase affordable health insurance. However, we are extremely concerned about the provisions in the H.R. 3103 concerning self-funded multiple employer welfare arrangements (MEWAs) and voluntary health insurance associations (VHIAs), and recommend that you work from the language in S. 1028. While we had understood that there were meaningful safe harbors for the states in the House language, careful reading belies such an interpretation. We believe that some of the safe harbors for states are substantially undercut by accompanying statutory language. Moreover, the safe harbors contain other ambiguous language that might be construed by the courts to further limit the scope of the safe harbors in the statutory language.

At this time, we will not offer specific examples supporting our concerns. Others, including the National Association of Insurance Commissioners (NAIC) have and will continue to provide further details of the relevant provisions. From our perspective as chief executive officers of states, we believe that the MEWA and VHIA provisions in the House bill run exactly counter to the steps we find advisable and necessary to continue improvements in the health care market. We do not need to look too far into the past to find traces of the adverse consequences of unregulated and poorly regulated entities. With respect to MEWAs, the problems were so significant that Congress acted in concert with the states and the U.S. Department of Labor to assure that these problems were corrected. These cooperative federal and state actions were the right thing to do. Now is not the time to reverse the trend. Now is not the time to reduce state regulatory authority, and now is not the time to destabilize the individual and small group insurance market. These provisions should be struck in conference.

***Protecting State Regulation of Insurance.*** As we said previously, maintaining and ensuring a meaningful role for states in the regulation of private health insurance is essential. Our reading of both the House and Senate bills suggest that you agree with our position and that the language has been crafted to maintain state authority and flexibility. That is, responsibilities have been 'saved' for states, and the states can go beyond the minimum federal standards. Unfortunately, we believe that the House legislative language has been drafted in a fashion that it is much more ambiguous than the Senate language on this point. With the exception of certain clear savings for certain state laws, state laws are preempted in areas "specifically addressed" by the bill. Since the bill "addresses", at least minimally, many areas, the preemptive sweep of these provisions could be very broad, however unintentional. For example, Section 131 requires guaranteed issuance of coverage in the small group market. The small group market is later defined as groups of at least two but fewer than 51. In a number of states, small group reforms include group size of 1 and in some cases groups larger than 50. The relationship between this federal preemption and state law is confusing and could result in judicial interpretations diminishing state regulatory authority to enact laws with broader guaranteed issue requirements. By contrast, the savings language in the Senate bill is much less ambiguous retaining state authority. We believe that the ambiguity in the House language is unintentional, and we are ready to work with conferee staff and the NAIC to correct the final conference language.

H.R. 3103/S. 1028 Conference

May 13, 1996

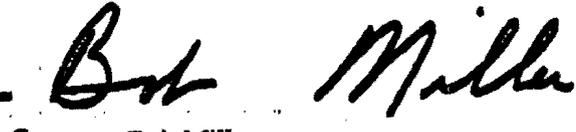
Page 3.

Thank you again for your attention to our concerns. We are committed to changes in the nation's health care system that expands the availability of affordable coverage to all Americans. Your work has been commendable, and we look forward to working with you in this most important area.

Sincerely,



Governor Tommy G. Thompson  
Chairman



Governor Bob Miller  
Vice Chairman

**Congress of the United States**  
**House of Representatives**

Washington, DC 20515

May 31, 1996

Honorable Newt Gingrich  
Speaker of the House of Representatives  
Washington, D.C.

Dear Mr. Speaker:

We are writing to express our opposition to certain provisions of HR 3103, the Health Coverage Availability and Affordability Act of 1996. This legislation, as passed by the House, contains language that would preempt state mandated benefits and other laws for small employer purchasing pools, called Multiple Employer Welfare Arrangements (MEWAs) and Voluntary Health Insurance Associations (VHIAs). This would have an extremely negative effect on consumers--especially women and children.

Throughout the 104th Congress we have heard about the wisdom of the states and the virtue of allowing states to regulate as they see fit. But HR 3103 would allow MEWAs and VHIAs to evade important state laws that protect women and children. According to an April 15, 1996 report by the General Accounting Office, some of the most common treatments required by states are:

- ◆ MAMMOGRAPHY SCREENING
- ◆ PAP SMEARS
- ◆ WELL-CHILD CARE and
- ◆ MATERNITY CARE

Health care professionals and patient advocates have worked hard to persuade states to recognize the importance of covering these health needs. All of these gains would be eliminated by the passage of HR 3103.

We are in favor of giving small businesses the ability to join together in order to have bargaining power in the health care marketplace. The Kassebaum/Kennedy legislation, S 1028, allows these businesses to form purchasing cooperatives in order to achieve savings without evading the decisions made by the state legislators and governors. Therefore, we are in favor of dropping the House provisions on these issues in conference and adoption of the Senate provisions. We are hopeful that a conference will occur and that it will produce meaningful legislation without politically divisive measures, which would only serve to derail this legislation and deprive our constituents of much needed reform.

Sincerely,

  
Blanche L. Lincoln, M.C.

  
Barbara B. Kennelly, M.C.

**National Conference of State Legislatures  
National Association of Insurance Commissioners**

May 8, 1996

The Honorable Bob Dole  
Senate Majority Leader  
United States Senate  
S-230 Capitol Building  
Washington, D.C. 20510

The Honorable Newt Gingrich  
Speaker of the House  
H33, The Capitol  
Washington, D.C. 20510

Dear Senator Dole and Mr. Speaker:

On behalf of the National Conference of State Legislatures ("NCSL") and the National Association of Insurance Commissioners' ("NAIC") Special Committee on Health Insurance ("NAIC Committee"), we are writing to express our views relating to H.R. 3103 and S. 1028, recently passed by the U.S. House of Representatives and the U.S. Senate, respectively.

The NCSL is a bipartisan organization created to serve the legislators and staffs of the nation's 50 states, its commonwealths and territories, and the District of Columbia. The NAIC, founded in 1871, is our nation's oldest association of state officials. Its 55 members are the chief insurance regulatory officials of the 50 states, the District of Columbia, and the four U.S. territories. The NAIC Committee, which consists of 37 of the states' chief regulatory officials, was established by NAIC members to review federal health insurance initiatives affecting state insurance regulation.

We believe that the Conference Committee, once appointed to resolve the differences between the proposals, will have a tremendous opportunity to approve legislation to enhance consumer protections and portability in health care coverage. However, the conferees will also have to resolve a significant difference between the two bills in the area of state authority over insurance as they attempt to reconcile two vastly different approaches to employer group purchasing arrangements.

Commendably, the broad outlines of the federal portability standards within both H.R. 3103 and S. 1028 reflect, and thereby acknowledge, the efficacy of already existing state reforms. *However, the acceptance in conference of Title 1, Subtitle C of H.R. 3103 would, at best, severely undermine, and at worst, potentially eviscerate the historic role of the states as regulators, innovators and implementors of health insurer solvency, market conduct and health insurance reform policy.* We respectfully request that Congress continue to be mindful of the ability of the states to experiment with novel solutions to new and developing problems in the areas under their jurisdiction and reject this section of H.R. 3103 in conference. Such an action would be consistent with the articulated goals of the 104th Congress to minimize the centralization of governmental authority in a large, expensive federal bureaucracy. The states have demonstrated, and continue to demonstrate, responsiveness and concern for the insurance marketplace and its consumers. States must be able to continue in this important role.

As detailed herein, the acceptance of H.R. 3103's sweeping and preemptive provisions relating to self-funded Multiple Employer Welfare Arrangements ("MEWAs") and Voluntary Health Insurance Associations ("VHIAs" -- a type of fully-insured MEWA) would have a deleterious effect on the integrity and force of state insurance regulation, consumers and, the insured marketplace. Such a decision should not be taken lightly. These provisions are, at their core, utterly inconsistent with a philosophy supportive of the states' efforts and authority relating to health insurance.

In this letter, we would like to emphasize the following nine points:

- The extension of portability reforms to beneficiaries of self-funded health care plans governed by the federal Employee Retirement Income Security Act ("ERISA"), a concept contained in both H.R. 3103 and S. 1028, would significantly enhance consumer protections in the area of health insurance reforms.
- H.R. 3101's provisions relating to MEWAs preempt state authority over those entities, including solvency regulation and, as to both MEWAs and VHIAs, undercut state authority and flexibility in the area of health insurance reform, would harm consumers, and should be rejected in favor of Section 131, Subtitle D of Title I of S.1028, "Private Health Plan Purchasing Cooperatives".
- The "savings" provisions added to the final H.R. 3103's MEWA and VHIA provisions *appear* to preserve state authority and certain state reforms; however, these "savings" are severely curtailed by complex layers of exemptions from these "savings" provisions and ambiguous legislative provisions that could be gamed.
- The legislation must clearly protect the states' ability to go further, and continue to innovate, in the area of health insurance reform.
- If the conferees accept H.R. 3103's provisions relating to administrative simplification, the interrelationship with, and effect upon, state laws addressing data collection and confidentiality of health information should be clear and state flexibility retained.
- The legislation should clearly set forth the types of state individual market reforms that meet the legislation's requirements. Objective criteria, as contained within S. 1028, best guarantee that the minimum federal standards will not have a chilling effect on state reforms of the individual market.
- We continue to recommend limited amendments to current provisions relating to Medicare anti-duplication to allow policies that sell long-term care benefits exclusively to coordinate their benefits with Medicare.
- The provisions governing the tax-deductibility of, and consumer protections for, long-term care insurance should clearly protect the states' ability to enact more stringent requirements to enhance consumer protections in the area of long-term care insurance.
- State enforcement authority in the area of health insurance should be retained, except in instances where states fail to *substantially* enforce the applicable standards.

#### **Important Extension of Consumer Protections and Portability Reforms**

We commend the provisions in both S. 1028 and H.R. 3103 that extend portability and other reforms to individuals covered by self-funded health care plans governed by ERISA. As you are aware, these reforms are already available to most beneficiaries of insured products. The NCSL and the NAIC have long called for a more "level playing field" in the marketplace in this area. We believe that the core of the group-to-group portability provisions within both bills will benefit many consumers who currently suffer from "job-lock" or the reimposition of preexisting condition limitations when they have responsibly maintained continuous health care coverage. In addition, the underlying structure and goals

of the provisions in both bills relating to portability from the group to individual market appear to attempt to preserve state flexibility in this area while also attempting to ensure meaningful coverage options.

However, as noted below, each bill's portability provisions are drafted somewhat differently and have the potential to interact with state laws in a different, and in some instances preemptive, fashion, even if that was not the intent. As the conferees discuss and negotiate several larger policy differences between the bills, we hope that attention will be paid to some of the more "technical" differences between the bills which have significant consequences. We continue to offer to help work with you toward the goal of setting clear, minimum federal standards which do not seriously alter, or place into jeopardy, states' existing authority over insurance.

### **Damaging Effects of Provisions Relating to MEWAs and VHAs**

H.R. 3103 and S. 1028 take very different approaches to the issue of employer group purchasing arrangements. The contrast between the bills' approaches on this issue is striking and of momentous import to consumers and state authority over the health care insurance market. S. 1028's provisions relating to private health plan purchasing cooperatives would largely complement state authority over health insurance and state insurance reform efforts. In contrast, H.R. 3103's MEWA and VHIA provisions would significantly undermine state authority and state-level solvency and consumer protections in the area of health insurance, as well as state-level insurance reform efforts. *As we have stated in the past, we strongly oppose Subtitle C of Title 1 of H.R. 3103.*

Notably, the final provisions in the House bill in this area contain several differences from the original H.R. 995. At first glance, the final language appears to attempt to save certain state reforms. However, the final language contains ambiguities and a confusing series of exemptions. This labyrinth guarantees, and at worst might be read to obfuscate, its net effect: the provisions do not meaningfully preserve state authority and reforms. We would welcome the opportunity to discuss the issues raised by the many layers of the bill's provisions in this area. A brief synopsis of some of the issues includes:

- The bill contains four layers of exemptions, including exemptions from exemptions from exemptions, whose conditions are extremely vague and therefore open to varying interpretations and possible "gaming;"
- the bill's "savings" provisions do not clearly preserve states' abilities to regulate the exempt entity, even in those states that may be able to apply some of their small group laws to such plans;
- the bill's notice and enforcement provisions are woefully inadequate if their aim is to provide the states with a meaningful way to intervene in the activities of entities which are operating outside of state or federal law; and
- the bill's "class exemptions" and "transition" periods provide entities with an opportunity to operate for a significant amount of time without receiving full certification from the Department of Labor that they meet the bill's requirements.

These are but a few of our concerns with this Subtitle. However, through these provisions, and other criticisms we have, there runs a common theme: the strides made by the states in the area of insurance reforms and stamping out fraudulent health care plans are threatened rather than preserved. If this failure was unintended, we offer to help you better understand its likely effect. These provisions ask the states to accept a serious impingement upon their authority in exchange for a very uncertain, and likely shaky, future for consumers and state policymakers.

### **State Flexibility**

We understand that members of the House and the Senate intended that the portability and insurance reform sections of their respective bills build upon existing state laws and preserve the states' ability to go further. The NCSL and the NAIC Committee respectfully request that the conferees carefully craft a "savings clause" that reflects their stated intent that federal standards operate in harmony with existing state law as well as their continued recognition that the states remain the primary regulators of the business of insurance in the United States. The "construction" clause in Section 201 of Title II of S. 1028 more clearly reserves flexibility to the states in the area of insurance regulation and reform.

Both bills' approaches to preemption raise some issues of ambiguity with respect to their effect on state law. Some level of uncertainty is possibly inherent within any attempt to craft legislative language that accurately reflects the framers' intent on every possible question that might arise in the course of a federal-state partnership, such as that contemplated under the bills.

S. 1028 saves state laws related to specific areas of health insurance reform "that are consistent with, and are not in direct conflict with, this Act and provide greater protection or benefit to participants, beneficiaries or individuals". In addition, the bill saves certain state laws that might otherwise be found to be in "direct conflict" with the group portability provisions of the bill. In the area of individual market reform, the provisions allowing for state alternative mechanisms appear to set forth the overriding test for state individual market reforms. If this is an accurate interpretation, we believe that this test currently contains ample flexibility for the states in the area of individual and group market reform. We would, however, welcome the opportunity to provide you with examples of the types of state reforms which we understand to be protected by the bill, for possible inclusion within legislative history (preferably within a Conference report).

It is our understanding that H.R. 3103 similarly seeks to allow the states to go further in the area of insurance market reforms. In fact, additional amendments made during several committees' markups further enumerated savings for some state reforms. We appreciate this intent; however, we have serious concerns that the current provisions of the bill would not effectuate that intent. The bill laudably attempts to limit its preemptive effect. However, it does this by limiting its savings of state laws to those laws relating to matters "not specifically addressed" in certain sections of the bill. Because the bill touches upon several areas of insurance reforms, however cursorily at times, state laws that relate to any of these areas are in jeopardy. We believe that members of the House did not intend for their legislation to have a chilling effect on innovative state-level insurance reforms and would welcome the opportunity to work with conferees of both Houses to craft language to address these concerns.

### **Individual Market Reform**

S. 1028 and H.R. 3103 each commendably attempt to set a minimal federal standard to guarantee that individuals who have been covered under a group health insurance contract for a set amount of time have access to health insurance coverage. Importantly, each bill also provides the states with the ability to "opt out" of each of the bill's standards if the state program meets certain set criteria. Prior to passage, the sponsors of S. 1028 made technical changes to their bill as originally introduced to lessen the discretion of the Secretary of the Department of Health and Human Services ("HHS") in reviewing a state plan. Both bills give the states an ample opportunity to correct their plans in response to the Secretary's concerns. However, S. 1028's criteria for alternative state plans are a bit more objective. It also reserves the opportunity to recognize models for individual reform currently under development by the NAIC. We find both of these aspects of S. 1028 to be worthy of incorporation in the final bill.

Importantly, we would like to alert you to a possible drafting error within H.R. 3103 that could have the possibly unintended effect of limiting states' abilities to go further in the areas of individual reform. The bill only clearly saves the states' ability to implement certain reforms and offer coverage beyond the scope of the bill's requirements; therefore, there remains an ambiguity as to whether a state could require insurers to make coverage available beyond the bill's scope. This ambiguity is likely unintended and we can provide technical, drafting suggestions should you desire.

In addition, we would like to raise questions with respect to the definition of "qualifying coverage" within H.R. 3103. It is defined as: "the weighted average actuarial value of the benefits" provided by an individual insurance carrier in that market, or, at a state's option, provided in the state's individual health care insurance market overall. This concept has not been widely tested in the marketplace and would appear to lodge significant discretion in the hands of the health insurers with respect to benefit package design, and the possible use of package design as an indirect means to attract individuals with low health care needs, while dissuading its purchase by "higher risk" individuals. S. 1028's explicit and objective safe harbors for state individual market reforms, which do not constrain the states to a particular, and ambiguous, definition of "qualifying coverage", better ensure the goals of meaningful portability and state flexibility.

#### Long-Term Care Insurance

Both S. 1028 and H.R. 3103 contain provisions, with slight differences, relating to the tax treatment of long-term care insurance. These provisions are extremely important because the deductibility of qualifying policies will likely drive the direction of the marketplace. Nonetheless, it appears that the states could still impose additional standards beyond those set forth for federal tax deductibility. This is less clear in the section governing consumer protections. We would ask that the states' latitude be made clear in both sections.

During the debate over S. 1028 on the Senate floor, Senator William V. Roth, Jr. provided the following response to a concern raised by Senator Edward M. Kennedy on whether the provision retains states' ability to enact more stringent long-term care consumer protections, "[I]t is not the intent of the leadership amendment to preclude States from enacting stronger long-term care consumer protections. A clarification of this issue can be addressed in the conference report to the bill if necessary." See Congressional Record, April 18, 1996, p. S 3608.

We appreciate this statement of intent relating to state flexibility and would ask for clarification on this point. This is especially important since the bills' provisions do not contain the same level of consumer protections as current NAIC models and state reforms in several areas. For example, the bills contain a very different approach from the NAIC models and state reforms in their definitions of, and conditions for, "benefit triggers", or events which cause a policy's coverage to "kick in." Unless the possibility of additional state requirements is made absolutely clear, states might not be able to enact greater consumer protections.

The possible preemptive effect of each bill's section relating to consumer protection standards is particularly stark. The requirements within the bills differ from the NAIC's current Long Term Care Insurance Model Act and Regulation. In fact, the consumer protection provisions of the bills reference an earlier NAIC model that does not have, among other areas, current provisions in the area of insurance suitability. As the NAIC and many states have taken further steps than those contained within the bill, it is imperative that this flexibility be retained. This section does contain language allowing the states to enact requirements "not in conflict with or inconsistent with" these provisions. Does this clearly

preserve states' ability to go beyond the bills' provisions? We would ask for amending language in the preemption section to make this clear and would prefer that the clarification be made in legislative language.

### **Administrative Simplification**

H.R. 3103 contains a section on Administrative Simplification not contained within the Senate bill. These provisions have a potentially sweeping effect on the information gathering and record retention of personal and general health information by state regulators and policymakers. Our initial examination of these provisions raises three primary concerns.

First, we recognize and appreciate the bill's provision that exempts from preemption those state laws that are more stringent than federal standards with respect to the privacy of individually identifiable health information. However, this exemption does not entirely alleviate our concerns because the bill does not specify the federal standards governing the privacy of individually identifiable health information, but leaves such standards for promulgation by the Secretary of Health and Human Services (HHS). It is therefore impossible to know how the legislation will affect the existing requirements of various states relating to such information. States may not know whether to enforce their own existing laws, and consumers may be worse off than under the existing system.

Second, we are concerned that the federal privacy standards ultimately promulgated by the Secretary might be construed by health carriers and plans as prohibiting them from disclosing critical information to state insurance departments. We request that the federal privacy standards explicitly protect the right of state insurance departments to obtain information necessary to regulate health carriers and health plans.

Third, the bill does not contain any specific savings clause for state laws addressing the standards, data elements, and code sets for the financial and administrative transactions specified in the bill. The bill accords the Secretary of HHS extensive authority over these transactions. The bill is ambiguous with respect to the Secretary's ultimate authority over the data standards for patient medical records, but this ambiguity also troubles us.

Federal preemption in this area will deprive states of the flexibility to pursue innovations in regulating a rapidly evolving technology.

### **Fraud and Abuse Provisions**

We would request language, in the final bill or in the Conference Report, to clarify that state insurance departments have access to the information in the national health care fraud and abuse database established by Section 221 of HR 3103 and a similar provision of the Dole amendments to S. 1028.

### **Medicare Anti-Duplication**

In prior letters, the NAIC Committee has clearly advocated a legislative change to enable long-term care insurance policies to coordinate their benefits with Medicare. (See NAIC letter dated January 27, 1995 to Secretary of HHS Donna E. Shalala; NAIC Committee letters dated September 19, 1995 and November 18, 1995.) This remains our position. In its March 28, 1996 letter to Speaker Gingrich, the NAIC

The Honorable Bob Dole and Newt Gingrich

May 8, 1996

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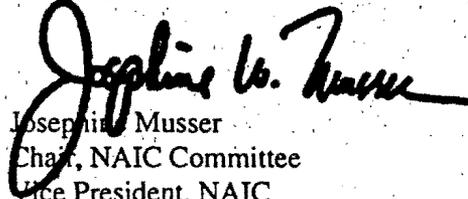
Committee commended the improvements in the final House language which went a long way to address concerns raised by the NAIC concerning earlier legislative proposals. This appreciation does not alter our preferred position on this issue, which remains a limited change in the area of policies selling only long-term care benefits. S. 1028 contains such a fix.

#### Enforcement

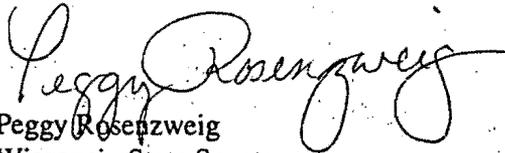
Both bills contain provisions retaining the states' authority to enforce the bills' standards for insurance reforms and portability. However, we would like to ensure that a single instance or failure of a state not be able to serve as a foundation for removing state authority. S. 1028 clearly states that federal intervention will arise in instances where the state has failed to *substantially* enforce the standards of the Act. H.R. 3103 provides for federal enforcement if there is a determination that such state "has not provided for enforcement of State laws which govern the same matters as are governed by such section and which require compliance by such entity with at least the same requirements as those provided under such section." We appreciate the House bill's reference to *state* enforcement of state laws in this area. We would only suggest that the addition of the word "substantial" before "enforcement" might clarify the fact that federal intervention is not contemplated on a case-by-case basis.

Once again, we would like to commend the members of Congress for taking important steps toward enhancing the portability of health insurance. We hope that the conferees will reject provisions which broadly preempt state laws, especially H.R. 3103's provisions relating to MEWAs. We offer our continued technical assistance as you move forward on this legislation.

Sincerely,



Josephine W. Musser  
Chair, NAIC Committee  
Vice President, NAIC  
Commissioner of Insurance,  
State of Wisconsin



Peggy Rosenzweig  
Wisconsin State Senate  
Chair, NCSL Health Committee

cc: Members, United States Senate  
Members, United States House of Representatives