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Comments on  
Multiple Employer Welfare Arrangement  
Provisions in H.R. 3103

AMERICAN ACADEMY OF ACTUARIES

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## **Multiple Employer Welfare Arrangement Provisions in H.R. 3103**

### **Overview of Provisions**

When two or more employers have formed a coalition for purposes other than purchasing health insurance coverage, they can then establish a health plan for their employees, known as a Multiple Employer Welfare Arrangement or MEWA. MEWAs can be self-insured or fully-insured. Under current law (ERISA), all MEWAs—both self insured and fully-insured—are regulated at the state level. However, only a minority of states actively regulate MEWAs. In fact, it is sometimes difficult for a state insurance department to identify MEWAs operating in its state, because MEWAs frequently operate across state lines.

The House-passed portability bill (H.R. 3103) would change how some self-insured and fully-insured MEWAs are regulated. Under the bill, a class exemption would be granted by the U.S. Department of Labor (DOL), on application, to large self-insured MEWAs that have been in existence for at least three years, and conditionally on review for a new MEWA set up by a qualifying sponsor that has been in existence for at least three years. These exempted self-insured MEWAs would be free from a broad array of state insurance market requirements, but they would be subject to federal solvency requirements and regulation under the jurisdiction of the DOL.

Like larger self-insured MEWAs, smaller ones could also opt for federal regulation if, upon application to DOL, the department deemed them to meet H.R. 3103's statutory requirements plus other requirements established through DOL regulation. Since it is so difficult for states to identify and regulate small self-insured MEWAs, it is unclear whether many would opt to be subject to federal regulation.

### **Intended Impact and Potential Unintended Consequences**

The intent of H.R. 3103 is to promote MEWAs as a mechanism for improving small employers' access to affordable health care. Allowing small employers to combine into MEWAs will give them greater buying power. The MEWA can represent its member employers, and, through their combined buying power, negotiate lower prices with health care providers — prices normally available only to larger organizations. With lower available rates, some small employers that currently do not provide health insurance may begin doing so.

While these are the intended results, H.R. 3103 is likely to lead to others that are less desirable. First, the bill requires that both the federal government and the states be fully equipped to regulate MEWAs. This is not only highly duplicative but will complicate the regulatory environment for everyone and potentially create opportunities for plans to game the regulatory structure.

Second, and more importantly, the bill permits self-insured MEWAs to choose between federal and state regulation. This provides a regulatory avenue that self-insured MEWAs can use to escape all or part of the health care reforms recently enacted in many states. Although the bill does address this issue, it does not appear to do so successfully. One of the provisions specifically designed to protect state reforms appears to apply to only one state. A second such provision applies to only two states. Thus, the bill potentially opens up the small group and individual health insurance markets in the states to the same kind of market segmentation that states have been attempting to reduce through localized state reforms.

Thus, as drafted, H.R. 3103's treatment of MEWAs raises many serious market issues, including the potential for increasing segmentation and premium differentials in the small-group health insurance market, destabilizing the individual market, exposing consumers to inadequate solvency standards and creating confusing and contradictory duplicative regulation. The remainder of this document discusses each of these issues.

### **Market Segmentation in the Small-Group Market**

H.R. 3103 contemplates that the MEWAs' affordable rates will result from volume discounts and increased market clout for the small employers that insure through them. As long as this is true, and as long as MEWAs attract a cross-section of health risks, the bill's provisions will not lead to increased segmentation in the small group and individual health insurance markets. However, MEWAs, in the form of the Voluntary Health Associations created under H.R. 3103, could encourage the splitting of the small-group market into healthy and unhealthy groups.

Freed from state regulation, federally qualified self-insured MEWAs could seek to attract the healthier small-employer groups through a variety of techniques (other than "volume discounts") not permitted under state regulation for insured health plans. They could, for example, offer benefit packages that appeal mainly to healthy individuals with low utilization patterns, establish new blocks of business with lower rates while allowing rates for older blocks to spiral upward, and market more aggressively to employers with generally healthier (e.g., younger) employees. As a result, the healthy groups would move into self-funded MEWA arrangements leaving behind an increasing proportion of less healthy, higher-cost groups in insured plans — those plans subject to the full force of state solvency regulation and small group reform laws. This would increase the premiums of insured groups since there would be fewer enrollees over which the higher claims cost can be spread. As premiums increased for those in the state-regulated markets, even more lower-cost employers would choose to participate in MEWAs. The resulting segmentation of the small employer group market into higher and lower cost groups would be exactly the type of segmentation that many state reforms have been designed to minimize.

Minnesota, one of the 47 states with small-group market reforms in place, is a good example of how the above effects could occur. Small-group insurance reform was enacted in July 1993 as part of the 1992 MinnesotaCare legislation and has proven successful in increasing access to coverage that is affordable for many small employers who had not offered coverage in the past. According to a December 1994 study conducted by the Minnesota Commerce Department, rates in the small-group market have stabilized over the past two years. In addition, a forthcoming University of Minnesota study shows that the rate of uninsurance among employees of small employers has decreased. Prior to the enactment of these reforms, small-group premiums increased almost annually, as do most premiums, compelling many small employers to drop coverage. A Blue Cross & Blue Shield of Minnesota research survey shows that 50% of its new small-employer groups had not previously offered group coverage.

The adoption of H.R. 3103's MEWA provisions could undermine much of the work the Minnesota legislature has done to make health insurance more affordable for small employers. By encouraging more and more small employers to join established MEWAs that are exempt from state health insurance requirements, such as state mandated benefits and restrictions on the range of premiums charged, small employers with less healthy individuals would face increased premiums and likely withdraw from the health insurance market.

### **Impact on the Individual Market**

A second MEWA issue under H.R. 3103 is their potential impact on the individual health insurance market. Allowing self-insured MEWAs for small employers (including groups as small as one or two) will reduce the size of the individual market because many persons who have bought individual insurance in the past may switch to MEWA coverage instead, potentially destabilizing the individual market. This destabilization is related to the group-to-individual portability provisions in H.R. 3103 and would ensue if a larger proportion of the high-cost persons remained in the individual insurance market, thereby inciting a claims spiral. An unstable and shrinking individual market could prompt carriers to leave the market, in turn leading to diminished access and affordability for the insureds currently in the individual market and for individuals who may need to access that market in the future.

Although a self-insured MEWA is not part of the state regulated insured small-group market, people who lose their MEWA insurance because of a COBRA-type event would have the same rights to guaranteed group-to-individual portability (also contained in H.R. 3103) as if they had been part of the insured marketplace. People who lose their job and opt for guaranteed-issue individual coverage rather than lower-cost underwritten individual coverage generally do so because they have higher health care costs. In most states, state regulations provide for the subsidization of these higher costs by small- and large-employer groups in the insured marketplace. Since self-insured MEWAs fall outside the purview of state regulation, the excess costs of those who leave MEWAs, will, by necessity, be borne by the other markets.

## **Solvency Standards**

Since benefits promised by MEWAs are the same as for any insurance product, MEWAs should be required to adhere to solvency rules similar to those that govern other health insurers. Capital, as well as adequate reserve requirements, is necessary to protect plan beneficiaries, because of fluctuations in cost or inadequate premium rates. The NAIC risk-based capital requirements could be imposed on a MEWA. These specify a capital requirement for a health insurer of at least \$500,000, plus 2 times an individual's lifetime maximum benefit, as a minimum for a start-up operation. For example, a plan with a \$1 million lifetime maximum benefit would need \$2.5 million of capital to commence operation, unless catastrophic claims are reinsured. This amount would increase in proportion to the total premiums as the MEWA grows.

## **Federal Regulation of MEWAs**

H.R. 3103 proposes that MEWAs be regulated by the federal government (specifically, the DOL). However, the DOL currently has neither the capability nor the resources to regulate these plans. In addition, consumers would not be clear who regulates their health insurance coverage—their state insurance commissioner or the DOL. To the extent that the DOL could develop the necessary regulatory structure and add additional staff, some degree of improved consumer protection could result in most states, since regulation is not currently being actively enforced.

H.R. 3103 could either be in conflict with state regulation or keep states from doing the amount of regulation they do now—which in some cases is not adequate. Apparently, a considerable change in the DOL would be required to serve as a regulator for all the issues discussed in this report, including surplus requirements, plan audits, adequacy of claim reserves, market conduct, and reviewing benefit plan designs, rating structures, contract forms, and advertising materials. All of this would require much additional effort to regulate. For those MEWAs that operate on a fully insured basis, states would continue to regulate insurance carriers and guaranty solvency standards. But for exempted self-insured MEWAs, state and federal regulatory costs would be duplicated, and the regulations themselves, could be in conflict.

## **Conclusion**

Overall, H.R. 3103's provisions for MEWAs may:

- Destabilize the small-group and individual insurance markets, potentially characterized by greater market segmentation, because of incentives for the most healthy individuals, and employers with the most healthy employees, to select less regulated exempted MEWAs that are lower cost.

- Create solvency risks, because MEWAs would not be subject to insurers' usual solvency rules, even though they are selling insurance-type coverage with the same risks as true insurance.
- Create a significant regulatory burden for the DOL, as its staff took on the extensive new task of insurance regulation.

We recommend that these issues be considered carefully and addressed, to minimize the possible adverse impacts on current insurance markets and critical regulatory enforcement and solvency issues.

# AMERICAN ACADEMY *of* ACTUARIES

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## **Domenici-Wellstone Amendment to S. 1028 to Provide Parity for Mental Health Benefits Under Group and Individual Health Insurance Plans**

Legislative language is subject to regulatory clarification and judicial interpretations. There is often uncertainty during the period of implementation and during the development of case law. In some instances, original intent is changed through that process. The Domenici-Wellstone Amendment could encounter problems due to uncertain language, undefined terms, and potential unintended consequences. The American Academy of Actuaries has reviewed the amendment and offers the following interpretations.

### **Overview of the Domenici-Wellstone Amendment**

The Domenici-Wellstone Amendment requires certain health plans to eliminate current coverage differences between mental and other health conditions. The Domenici-Wellstone Amendment does not include alcohol abuse, substance abuse, or chemical dependency under the term "mental health." Having the same coverage "as any other illness" is referred to as "parity." The amendment will supplement existing state requirements and mandates for mental health coverage.

The Domenici-Wellstone Amendment does not require employers to provide mental health benefits. However, state laws may require mental health coverage. If mental health is covered, health plans will not be allowed to impose treatment or financial limits on mental health services that are not imposed on services for other health conditions. For example, health plans will be required to use the same level of deductibles, coinsurance, copayments, and out-of-pocket limits for mental and physical conditions. There can be separate but equal cost-sharing provisions. That is, the deductibles, copayments, and out-of-pocket limits do not have to be under a common accumulation of patient cost sharing.

With regards to premium payments, employers cannot require employees to pay a separate premium for mental health or require a different level of premium sharing from other coverages. Equal percentage of premium sharing between employers and employees will be allowed.

Health plans will no longer be able to have coverage limits on inpatient or outpatient mental health services that are different from other health conditions. Other health conditions are usually covered without a day limit on inpatient care and without a limit on visits to providers. Other health coverage is usually provided until a maximum lifetime plan limit is reached. Mental health care is frequently covered with a limited inpatient benefit of 30 to 60 days. Outpatient mental health is frequently covered with higher patient cost sharing (50% versus 20% patient payment) and limited to a maximum number of visits per year (typically 20 to 50 visits). Both inpatient and outpatient

mental health benefits are frequently restricted to a maximum lifetime or annual limit much lower than that for physical conditions (e.g. \$25,000 versus \$1 million).

### **Plans Under the Jurisdiction of the Domenici-Wellstone Amendment**

- An employee health benefit plan—a self-insured plan established by an employer under ERISA.
- A group health plan—an insured contract between a health plan insurer and an employer. The Domenici-Wellstone Amendment applies to all such groups regardless of employee size.
- An individual health plan—an insured contract between a health plan insurer and an individual. For example, this would include individual major medical plans, hospital-only plans, and basic medical coverages.

### **Plans Not Under the Jurisdiction of the Domenici-Wellstone Amendment**

- Association plans—insured plans typically bought by individuals who are a part of an association that offers insurance under separate state regulations for association plans. Depending on state regulations and definitions, some association plans may be covered by the amendment. (It is unclear whether association plans are included or excluded.)
- Specialty products/dread disease—insured plans sold to individuals that provide coverage for specific health conditions. Excluded are accident-only, disability income or any combination thereof; coverage for specified disease or illness, hospital or fixed indemnity insurance; short-term limited duration insurance; credit-only, dental-only, or vision-only insurance; long-term care, community-based care, or any combination thereof; and Medicare supplement policies.
- Other plans—liability supplement, liability insurance, general liability, automobile liability, workers' compensation or similar insurance, and automobile medical payment insurance.
- Medicare—federal health care program for persons 65 and older and some disabled.
- Medicare risk contracts—Medicare replacement contracts sold under approval by the Health Care Financing Administration.
- Medicaid—federal/state health care program for the poor.

### **Managed Care Under the Domenici-Wellstone Amendment**

The amendment allows some managed care controls for the approval, authorization, and coverage

of mental health benefits. These limitations to establish medical necessity may apply, even if they apply only to mental health care:

- Preadmission screening—review of any hospital admission or outpatient treatment plan.
- Authorization of coverage—this could apply to both inpatient and outpatient coverage.
- Other unspecified limitations—procedures that restrict coverage for mental health services to those services that are medically necessary.

The Domenici-Wellstone Amendment does not prohibit:

- Mental health carveout programs—mental health care programs segmented to specialty network managed care services.
- Mental health risk sharing—alternative payment methods to providers under capitation or other financial arrangements.

### **Potential Impact of the Domenici-Wellstone Amendment on Insurance Premiums**

The impact on insurance premiums and self-insured plan costs will vary depending on the current level of coverage provided. Some private actuarial studies have been released that demonstrate that increases will vary depending upon assumptions. The Congressional Budget Office (CBO) estimates an increase of 4.0% in total health premium costs. CBO estimates the employers share of that cost increase at 1.6% of total health premium costs.

### **Potential Impact of Expanded Private Coverage on Public-Sector Expenditures for Mental Health**

There is a difference of opinion on the effect of expanded private coverage on public-sector expenditures for mental health. One study indicated that up to one-third of the current government expenditures would be "privatized." This would produce a public savings of \$16.6 billion, while market efficiencies would limit private sector cost increases to \$14.4 billion or 3.2% of premiums. The CBO has not made an estimate of public-sector savings.

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# Actuarial Equivalence Provisions in H.R. 3103

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## Actuarial Equivalence Provisions in H.R. 3103

### Overview

H.R. 3103 requires each carrier (insurers and HMOs) to guarantee-issue one "qualified" health plan, i.e., a plan that is at least "actuarially equivalent" to a defined average plan for that carrier in question and to plans offered by all carriers in the state. It does *not* require carriers to guarantee issue any of their other products. Under H.R. 3103, a plan is defined as actuarially equivalent to another plan if both plans produce benefits of equal value, in an amount or a series of amounts payable or receivable at various times. As structured under H.R. 3103, actuarial equivalence is intended to allow carriers to guarantee-issue to applicants only one plan from their portfolio, and this plan must provide significant benefits, as contrasted with policies that offer only relatively limited benefits: a hospital indemnity policy, for example, or a catastrophic high-deductible policy.

However, using the concept of actuarial equivalence is an extremely complex way to achieve the goal of providing significant benefits. Under H.R. 3103, "qualifying" individual coverage is based on a weighted-average actuarial value of the benefits provided by all individual health insurance plans issued by one carrier in the state during the previous year, or by all carriers in the state during the previous year. While this approach is designed to let the marketplace determine the value of the benefits, it will prove, in practice, cumbersome for states to administer. It will also be difficult for states to keep it up-to-date, because the mix of plans in the market changes rapidly over time. In fact, its complexity could prevent it from accomplishing what the bill intends.

The requirement to guarantee-issue a single plan, rather than a carrier's entire portfolio, may be more appealing to carriers, because it would make it easier to monitor the situation and segregate these "higher risk" individuals in plans separate from their other standard-population plans. Maintaining this segregation would not disrupt carriers' freedom to design and thus market plans tailored to their market strategies. In some states, even pricing will not be disrupted, because regulation allows premiums for the guarantee-issue population to be calculated separately (and higher) from their standard-population plans. However, in other states, carriers' entire individually insured population would need to be combined for setting the premiums, because of state restrictions on rate variations.

### How Actuarial Equivalence Could Work

At the present time, both the definition of actuarial equivalence and the methods for determining whether plans are actuarially equivalent—especially in reference to individual health insurance policies—are highly imprecise. Definitions differ substantially according to context and are used in diverse ways in actuarial literature and practice. Thus, it is incorrect to assume that the definition and the methodology pertaining to actuarial equivalence are universally agreed upon—even among the experts charged with calculating whether plans are equivalent.

Under H.R. 3103, what's required is that a "qualified" guaranteed-issue plan have a stream of benefit payments that are actuarially equivalent to those of another plan. It is not necessary that the stream of premium payments for the two plans be the same. Consequently, a judgment about the worth of benefits over time must be made. Herein lies the technical problem: how to objectively calculate the value of the benefits at any point in time without the objective measurement needed to do so. To account for the lack of objective measures, assumptions must be made. Under H.R. 3103, assumptions must not only be made to measure the worth of all benefit combinations carriers offer in their individual health plans, but, in addition, assumptions must be made for the lifetime of the plan, the time value of money (interest rates), death rates, and persistency. It would be difficult for all carriers or regulators to agree to standard interest rate, lapse rate, and death rate assumptions.

### **Actuarial Worth of Benefits**

While the bill does not address several measures—the lifetime of the plan, the time value of money (interest rates), death rates, and persistency assumptions—it does contain language that attempts to address the worth of any one benefit relative to another and appropriately recognizes that benefit costs vary by risk factors such as age. However, the bill stops short of total resolution of this problem by simply stating that actuarial value be calculated using a "standardized population and a set of standardized utilization and cost factors," without suggesting how such standards would be established. The bill, as currently drafted, appears to assume that such standardized factors already exist or are easily attainable—neither of which is true.

Since the bill does not answer the questions of how these standards will be determined, it ignores the cost of the state regulatory effort required to establish such standards—particularly the cost of setting up new regulations and keeping them updated. The costliest component in standards development would be the process of achieving agreement on a uniform set of assumptions, when consideration is made for the fact that different carriers design benefit plans to appeal to populations in different demographic settings, such as rural versus urban settings. Someone will have to decide who would arbitrate in this case. And more importantly, if the markets are different, it must be decided how to justify why one set of assumptions would be appropriate for both settings.

### **Lifetime of a Plan**

Another complicating factor is the determination of the duration of the stream of benefit payments in an individual health insurance plan. Individual health insurance plans are not simply annual plans that are renewed each year with comparable characteristics, as is typical for group health insurance. For example, for traditionally underwritten plans, in the first year after issue, costs are low because of calendar-year deductibles and the generally better health of insureds in this period. (The opposite is true for guaranteed-issue plans, which makes it dependent upon the duration of the plan—an additional complication for determining the worth

of a benefit.) Does that imply a need for a standard set of assumptions by the year the plan is issued? Probably not, but it does mean that for an actuary to perform actuarial equivalence calculations, somehow he or she must consider either the durational mix of the business or the entire future potential series of benefit payments over the lifetime of the plan with or without new issues. The latter approach becomes highly problematic because future premium rate increases have a significant impact on lapses and, therefore, on the material life of the plan.

Some insurance regulators and some carriers will deal with this "lifetime of the plan" problem by claiming that individual health insurance plans are priced one year at a time (like group health plans), so only the present year of benefits need be addressed. Others will argue that these plans are priced for several years in the early life of a new product series, and then priced as though they annually renew at the same cost, because there is usually a mix of new and mature business in every block of health insurance. Thus, the question of what constitutes the lifetime of the plan for the purpose of performing actuarial equivalencies requires an answer that is not obvious. The range of answers that could be justified is between one year and years to age 65.

### **Time Value of Money, Persistency, and Death Rate Assumptions**

Calculating actuarial equivalence requires assumptions for the time value of money (interest rates), persistency, and death rates. Establishing assumptions for death rates would not be controversial, and the establishment of interest rate assumptions to account for the time value of money would be only relatively problematic (because it deals with future periods of time when the investment environment is uncertain). However, determining persistency assumptions would be more difficult, because these assumptions are subject to extreme variation among differing carriers. In performing an actuarial equivalence test of one plan against another, the number of policyholders that persist into the future will depend on how long it's been since the plan was purchased and how large future premium rate increases will be—the latter is at the discretion of each carrier.

### **Weighting**

In addition to accounting for the worth of benefits, lapse rates, the time value of money (interest rates), and the lifetime of the plan for calculating actuarial equivalence, it is also necessary to develop procedures for agreeing, every year, on how to "weight" plans. H.R. 3103 requires a determination of a weighted-average actuarial value of benefits for plans within a given carrier's portfolio and among all other carriers in the state. In the absence of a standardized weighting methodology, there could be a considerable amount of gaming.

### **Managed Care Networks**

Next, there is the problem of evaluating equivalence for plans that contain network (preferred provider organization or health maintenance organization) and non-network features. How would this be accomplished? Network and non-network product portfolios will likely have

widely differing standardized cost and utilization factors, despite the fact that the benefits may be identical, except for the site of treatment.

### **Implementation Considerations for Carriers and State Regulators**

If actuarial equivalence were based on individual coverage offered by all carriers in a state, that state would likely commence a regulatory process by possibly requiring all carriers to agree on a standard method for valuing the benefits provided under their individual health insurance plans, i.e., the "standardization" process discussed above and referred to in the bill. To accomplish this, the state may have to devise a statewide benefit package to use as a benchmark. This would be difficult, both politically and administratively. In particular, determining statewide actuarial equivalence—combining the products of all carriers—would be an extremely burdensome exercise for regulators.

When carriers alter their individual benefit package, by, say, adding new drug benefits or additional hospital days after delivery of a baby, the statewide standard benefit package would have to be updated. In theory, the regulation should be updated simultaneously, but in practice, many years might pass, which could jeopardize compliance with the federal requirement in H.R. 3103. These new responsibilities would put greater burdens on the state, and likely compel it to add staff and other administrative resources to establish, monitor, and police compliance with H.R. 3103's actuarial equivalence provisions.

For a state that took such a statewide standard benefits package plan approach, carriers would probably consider taking one of two routes: adopting (implementing) the state standardized plan, which likely would mean updating it as often as annually, or, as an alternative, start guaranteeing their next most generous plan design.

In addition, compliance with statewide actuarial equivalence (in contrast to actuarial equivalence within a carrier's portfolio of plans) could be disadvantageous to carriers that currently only offer plans with limited benefits: they would be newly required to offer products for which they have no management experience. This will be especially true for smaller carriers.

### **Minnesota's Experience with This Type of Requirement**

Minnesota has had an actuarial equivalence requirement for group and individual policies in place since 1976. Every potential benefit within a plan is assigned a specified number of points (established by state rules), and all carriers are required to tabulate the points for every benefit plan they sell. Benefit plans are ranked according to the total number of points—the higher the number of points (i.e., the greater the number of benefits included as part of a benefit plan), the more generous the benefit plan. The provision was originally intended for use in setting benefit levels and to provide tax incentives to prompt employers to meet the benefit minimums. However, in point of fact, actuarial equivalence has been largely ignored by elected officials in the state over the last decade; the 1992 MinnesotaCare reform did not include actuarial

equivalence as part of the state's insurance reform; and the factors are rarely updated for benefit relationships. The high prevalence of managed care in Minnesota is an additional factor that makes it difficult to determine actuarial equivalence.

The Minnesota experience suggests that actuarial equivalence is difficult to set up, difficult to maintain, and ultimately does little to define market standards.

### **Likely Impact on Consumers**

When carriers are required to guarantee-issue only one "qualified" actuarially equivalent plan, consumers have the assurance that that plan provides significant benefits. Thus, they will not need to acquire sophisticated knowledge about health plans before choosing among them. However, consumers who are more sophisticated about the health insurance market, and would like to choose from a roster of plans the one that best meets their needs, would be prevented from doing so. For example, a young, healthy individual who may want to buy more limited coverage could not, because that plan would not be actuarially equivalent and would thus not be "qualified" as the guarantee-issue plan.

### **Conclusion**

H.R. 3103's actuarial equivalence provision requires carriers to guarantee issue one "qualified" plan from their portfolio. A qualified plan is one that ensures that individual-market plan participants have access to significant health insurance coverage, because the guarantee-issue plan is deemed to be actuarially equivalent to a defined average plan for that carrier in question and to plans offered by all carriers in the state. However, requiring that available plans be actuarially equivalent to the weighted-average plan offered may not be an efficient way to achieve this goal. In fact, it may even render the goal more difficult to achieve, because of the introduction of numerous highly complex regulatory and administrative compliance responsibilities.

Determining actuarial equivalence inevitably requires some degree of subjectivity. Determining actuarial equivalence, as required under H.R. 3103, requires actuarial opinion, which can be done if states are willing to cede that responsibility and control to carriers. To do otherwise, as with any other opinion, would leave the decision subject to continual challenge and state bureaucratic expense. Simpler mechanisms to achieve the goals of H.R. 3103's actuarial equivalence provisions are available. The Academy's Guaranteed Issue/Universal Access Work Group is available to discuss these options.

Table 2: Commonly Mandated Benefits

	Number of states		
	Cover	Offer	Total
<b>Treatment-related</b>			
Mammography screening	42	4	46
Alcoholism treatment	23	16	39
Mental illness	15	16	31
Well-child care	21	4	25
Drug abuse treatment	13	10	23
Pap smear	17	0	17
Infertility treatment/ in vitro fertilization	12	2	14
Temporomandibular joint disorders	11	3	14
Off-label drug use	13	0	13
Maternity care	11	2	13
Breast reconstruction following mastectomy	9	2	11
<b>Provider-related</b>			
Optometrists	46	1	47
Chiropractors	43	3	46
Psychologists	42	0	42
Podiatrists	38	0	38
Social workers	26	0	26
Osteopaths	21	0	21
Nurse midwives	15	0	15
Physical therapists	14	0	14
Nurse practitioners	13	1	14

Source: NAIC, Compendium of State Laws on Insurance Topics: Mandated Benefits (Kansas City, Missouri: NAIC, 1995).

MEWA File

## TALKING POINTS ON HOUSE MEWA PROPOSAL

**Background:** Under a 1983 amendment to ERISA, health arrangements involving employees of two or more employers were termed "multiple employer welfare arrangements," or MEWAs. MEWAs essentially are unlicensed insurance companies, many of which try to escape state insurance laws by claiming preemption under federal law regulating employee benefit plans. For 16 years, states have had primary jurisdiction over MEWAs for solvency and other insurance regulation, with federal back-up through ERISA's fiduciary standards. The House proposal would allow most MEWAs to get out from under state insurance laws, placing them in a regulatory nether world and giving them a cost advantage over insured policies subject to state solvency and other requirements.

### **Federalized MEWAs Threaten State Small Group Markets.**

By allowing federalized MEWAs to escape from state insurance laws and offer coverage at a lower cost than insured policies, MEWAs could cherry pick good small business risks.

The danger of an exodus of small firms from state-regulated small group markets is that only employers with high risk populations will be left in them, facing escalating premiums.

It would thwart state efforts to implement more comprehensive reform; all but 4 states have enacted small group market reforms to help small employers.

### **Workers Get Less Protection under Federalized MEWA Regulation.**

The current regulatory framework places MEWAs under state regulation because it recognizes that they are more like insurers than employee benefit plans. As with insurers, MEWAs currently have to provide consumer protections required under state law.

Workers whose coverage is switched from state-regulated policies to federalized MEWAs lose the protection of state guaranty funds, mandated benefits, and such other consumer protections as information disclosure and fair claims procedures without gaining comparable federal protections.

### **Enforcement of the House Federalized Scheme Poses Serious Problems.**

Noncompliance is virtually guaranteed by the bill's convoluted structure. It would result in at least three categories of MEWAs with at least 12 different rules or exceptions thereto and would require the Department to implement extensive and complicated procedures in an era of shrinking resources.

Republican and Democratic Administrations have cracked down on fraud by MEWAs trying to evade state oversight. The bill's convoluted scheme threatens this good track record. It presents an open invitation to unscrupulous MEWA operators to perpetuate their long pattern of abuse by allowing them to self-certify that they meet the bill's federal standards.

The stakes are too high for working families who could lose their health benefits altogether and find themselves saddled with unpaid medical claims.

### **Workers are Protected through Purchasing Cooperatives.**

The right way to help small firms strengthen their purchasing power is through purchasing cooperatives that offer insured health policies to workers in small firms, as Senators Kassebaum and Kennedy have proposed, retaining the protections afforded working families by state insurance regulation. Purchasing cooperatives have a more targeted preemption of state rating and mandated benefit laws and would be required to take employers on a first-come, first-served basis, boosting small firms' purchasing power without causing a major shift to self-funded arrangements.

## Summary of the MEWA Provisions in H.R. 3103

The reference numbers in bold are to the new Part 7 of ERISA added by the bill in section 161 unless otherwise noted.

### **The Difference Between a MEWA and a MEHP**

Multiple employer welfare arrangements (MEWAs) as defined under ERISA provide health benefits to the employees of two or more employers. MEWAs are currently regulated by the States for solvency, financial reporting and other requirements of State insurance law, including consumer protection measures, but remain subject to ERISA's fiduciary standards. Generally under H.R. 3103 a self-insured MEWA offering only medical benefits could seek an exemption from DOL in order to be excluded from State regulation. These exempted arrangements, known as multiple employer health plans (MEHPs), would be subject to federal standards under ERISA regarding financial, actuarial/solvency and other reporting requirements. MEWAs that do not obtain an exemption remain subject to State regulation. [702] Fully-insured MEWAs may operate as voluntary health insurance associations, which are discussed on page 3.

### **Must a MEWA Go Through the Exemption Process to Become a MEHP?**

Yes, but due to a class exemption in the bill it appears only small MEWAs would need an exemption before operating as MEHPs. MEWAs already in existence for at least 3 years with either (A) at least 1,000 covered participants and beneficiaries or (B) at least 2,000 employees of eligible participating employers under the MEWA could self-certify that they met the requirements at the time they applied for an exemption. The exemption would then be treated as granted unless and until DOL provided notice that it had been denied. [702]

### **Who Can Sponsor a MEHP?**

MEHP plan sponsors must have been organized and maintained in good faith for at least 5 years with a constitution and bylaws stating the MEHP's purpose and providing for periodic meetings at least annually. They must be a trade, industry or professional association or chamber of commerce and operate on a cooperative basis for purposes other than providing medical care. They must also be permanent entities with the active support of their members and collect dues or contributions that are not conditioned on health status. [703]

### **Do MEHPs Have the Same Requirements as Insurers and HMOs?**

The bill's provisions on guaranteed renewability and preexisting condition exclusions would apply to MEHPs as well as insurers and HMOs. The guaranteed availability requirements, however, differ as insurers and HMOs offering coverage in the small group market must accept every small employer in the State who applies. [Act Section 131] In contrast, although the self-insured MEHPs are required to make the health benefits coverage available to all employers who are members, they are not required to accept as members all employers who seek to join. [703]

### **Are There Solvency Requirements for MEHPs?**

MEHPs must maintain reserves sufficient for unearned contributions and for benefit liabilities incurred but not yet satisfied, and for expected administrative costs. The minimum amount for the reserves would be the greater of (1) 25% of expected incurred claims and expenses for the plan year, or (2) \$400,000. DOL may provide additional requirements relating to reserves and excess/stop loss coverage. [705]

### **How Are the MEHP Requirements Enforced?**

ERISA Part 5 enforcement mechanisms would apply in addition to a \$1,000/day penalty for the failure to file information requested by DOL. States could enter into agreements with DOL regarding the enforcement of the federal standards for MEHPs but DOL would still retain concurrent authority. [Act Sections 167 and 168]

### **Are States Allowed To Tax the MEHPs?**

States may impose premium taxes on MEHPs that are established after 3/6/96 or, if already in existence on that date, commenced operations in the State after 3/6/96. [708] Thus, it appears that States would only be able to tax new MEHPs.

### **Do States Have Any Additional Authority to Regulate MEHPs?**

As described below, the bill would allow States considered to have achieved "guaranteed access" to exercise some additional regulatory authority over MEHPs.

Guaranteed Access States - If a State certifies to DOL that it provides its residents with guaranteed access to health insurance coverage then it may regulate health care coverage provided in the small group market (or prohibit the provision of such coverage) by a MEHP.

"Guaranteed Access" means (A) 90% of the State's residents have health insurance coverage or (B) there is guaranteed issue in the small group market for employees for at least one option of coverage offered by insurers and HMOs and the State has implemented rating reforms designed to make coverage more affordable. [708]

Exceptions for Certain MEHPs - Regulation by States that certify they have guaranteed access does not apply to MEHPs that-

(1)(a) operate in the majority of the 50 States and in at least 2 regions of the U.S.; (b) cover at least 7,500 participants and beneficiaries, and (c) do not have an enforcement action by the State pending at the time of application for the exemption; or

(2) were operating in the State as of 3/6/96 (regardless of size) and did not have any enforcement actions pending against them.

In addition, DOL may provide for an exemption in regulations from requirement (1) (a) for certain MEHPs that are limited to a single industry. [708]

**Comment:** These exceptions and limitations appear to have the effect of allowing States to regulate only new small MEHPs.

**Specific Carve-outs** - The above two exemptions do not apply to any State that as of 1/1/96 had laws that either provided guaranteed issue of individual insurance using pure community rating or required insurers of group health plan to reimburse insurers offering individual coverage for losses resulting from the offering of such coverage on an open enrollment basis. These two States are believed to be New York and New Jersey. [708]

### **What Is a Voluntary Health Insurance Association?**

A voluntary health insurance association is a fully-insured MEWA maintained by a qualified association whose benefits include medical care. In general, the requirements for voluntary associations are very similar to those cited above for MEHPs, such as being in existence for 5 years with a constitution and bylaws, being a permanent entity with active support of its members and collecting dues or contributions that are not conditioned on health status. In order to escape State regulation in States that certify they provide guaranteed access, large multistate associations and associations in existence as of March 6, 1996 may not exclude from membership any small employers in that State. [Act Section 162]

### **How Do the Purchasing Cooperatives under the Kassebaum/Kennedy Bill (S. 1028) Differ from the MEHPs?**

Under S. 1028 voluntary purchasing cooperatives may be established to provide employers and individuals with access to fully-insured health plans. The cooperatives negotiate with health care providers and health plans, prepare and distribute plan materials, market the plans and act as an ombudsman for enrollees. The cooperatives may not perform any activity related to health plan licensing, assume financial risk in relation to the health plans or exclude anyone based on health status. The cooperatives must generally be not-for-profit with an exception for those run by non-profit organizations.

The cooperatives are certified by the State, chartered under State law and registered with DOL. If a State fails to implement a certification program then DOL shall certify the cooperatives and oversee their operations. The requirements of parts 4 (Fiduciary Responsibility) and 5 (Administration and Enforcement) of title I of ERISA apply to the purchasing cooperatives.

## FEDERALIZED MEWA REGULATION

Under current law, employers may band together to purchase health insurance for their employees, either on their own or through collectively bargained arrangements. Most such plans that are not the result of a collectively bargained agreement are known as multiple employer welfare arrangements, or MEWAs, and are subject to ERISA. Among other things, ERISA specifies that MEWAs are subject to state health insurance regulation in addition to ERISA's fiduciary standards. This dual jurisdiction reflects the fact that MEWAs essentially act as insurance carriers.

The insurance reform bill passed by the House (H.R. 3103) would create new federally regulated MEWAs called multiple employer health plans, or MEWAs, that would not be subject to state regulation. H.R. 3103 gives federalized MEWAs a competitive advantage over insurers that are required to meet tougher state insurance standards, allowing MEWAs to attract small employers currently able to afford and offering insured health coverage. Without regard to state requirements imposed on their competitors - insurers - H.R. 3103 would give federalized MEWAs the authority to: 1) restrict eligibility to selected employers with low risk populations; 2) vary rates for reasons other than health status or claims experience that could make coverage prohibitively expensive for employers with high risk populations; and 3) offer cheaper coverage than insurers by avoiding state solvency requirements that may be stricter than the federal standards, as well as state premium taxes (except for new small federalized MEWAs).

**Threat to small group insurance market:** Because federalized MEWAs would not be subject to state insurance regulation, the bill would dramatically reduce states' long-established authority, ignoring the expertise that states have acquired over decades of insurance regulation. Encouraging employers to move out of small group insurance markets into federalized MEWAs could result in skimming the good risks from the small group market, thus thwarting states' efforts to effectively pool risks in the small group market. The likelihood of such an effect is dramatically increased because federalized MEWAs would not be required to market to or take all comers. The danger of this cherry-picking is that only high risk individuals will be left in the state-regulated small group pools, leading to skyrocketing rates that those left in the state pools could not afford.

**Consumer financial protection:** Under existing law, participants and beneficiaries who receive insured coverage, whether through a MEWA or a single employer, have a state guaranty fund to protect their benefits if their insurer becomes insolvent. H.R. 3103 does not provide for a federal guaranty fund or similar source of protection. If a series of federalized MEWA failures occur, consumers and employers might look to the federal government, and the specter of another federal bail-out of the scope of the savings and loan debacle could rise.

**Dual jurisdiction strengthens anti-fraud enforcement:** State and federal governments have successfully recovered millions of dollars in premiums and unpaid claims for participants and employers. For example, state and federal governments have detected and taken action against: a MEWA in Florida with 40,000 participants that left \$29 million in unpaid medical claims; a MEWA in Massachusetts where the operators diverted over \$1 million in premium payments,

the collapse of which left more than \$4 million in unpaid claims, with individual claims of as much as \$250,000; a MEWA in Colorado that left 3500 victims with over \$5 million in unpaid claims; and an employee leasing scheme in North Carolina where operators embezzled \$1.2 million, which covered 1300 health plans located in 37 states.

**Enforcement of H.R. 3103 would require significant federal funding:** The federal regulatory structure set forth in H.R. 3103 would be difficult for the federal government to enforce in this era of dramatic federal budget cuts and bipartisan efforts to achieve a balanced federal budget. For example, the Department of Labor alone would have to issue a substantial number of new regulations just to establish the major exemption program for federalized MEWAs. In addition, the convoluted scheme created by the House bill would be difficult for all parties to understand and implement, making it tough to enforce and protect the benefits promised to workers and their families.

**H.R. 3103 moves authority from the states to the federal government:** The House proposal to create federalized MEWAs runs counter to House members' otherwise strong efforts to decentralize authority from the federal to the state level. Rather than creating a new federal bureaucratic framework, we should build on the strengths of today's coordinated enforcement efforts by state governments and the Department of Labor to enhance the purchasing power of small employers in getting and maintaining health coverage for their workers.

**Employer group purchasing works without federalized MEWAs:** Federalized MEWAs free of state regulation are not needed to allow small employers the benefits of strong purchasing power. Statistical analyses support the proposition that a group of 5,000 individuals is large enough to adequately spread health risks. We know from the April 1993 Current Population Survey that even the smallest state has at least 25,000 people (not including their dependents) who work in firms of under 100 employees and who are not offered health insurance coverage by their firm. This is more than five times the number of people needed to form an adequately sized risk pool - without going beyond state boundaries.

Small employers should be encouraged to join together to share the efficiencies and purchasing muscle that larger groups enjoy, but in a manner that retains the protections afforded by state insurance regulation. Senators Kassebaum and Kennedy as well as President Clinton propose to help employers band together through purchasing cooperatives that offer insured health coverage to workers and their families.

The purchasing cooperative proposal builds on many years of state experience in regulating and overseeing health insurance and provides another means for states to increase coverage and lower costs. Although it addresses many of the same issues as the House MEWA provisions, the proposal does so in a less radical and disruptive way. Purchasing cooperatives have more protective rating restrictions, are subject to the same mandated benefits requirements as others in a state's small group market, are required to market coverage to all small employers, and retain other protections of state law. The House bill, however, would have almost the opposite effect: it would undermine the state regulatory system and make it more difficult for states to develop comprehensive state-wide reform.

*Church Issue**Multiple Employer Welfare Arrangement**(MEWA) FILE***WILLIAMS & JENSEN**  
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GEORGE G. OLSEN**MEMORANDUM**

TO: Chris Jennings  
Assistant to the President for Health Policy

FROM: David A. Starr *DS*  
Williams & Jensen, P.C.

RE: Church Alliance Concerns with S. 1028

My partner, Butler Derrick, has scheduled an appointment with you for Thursday, April 25 at 10:00 a.m. We will be accompanied by representatives (names and denominations to follow) of the Church Alliance, a coalition of mainstream denominational church benefit plans (list attached). Butler asked me to provide you a description of the concerns the Alliance has with respect to S. 1028, the Kassebaum-Kennedy health insurance reform bill.

Church pension and welfare plans are expressly exempt from ERISA Title I rules. This exemption reflects the special consideration Congress gives churches because of separation of church and state concerns. S. 1028 for the first time would subject church health plans to federal regulation. Church plans are unique in that they are frequently maintained by a church, or convention or association of churches, to provide coverage to the denomination's local churches. Even the term "employee" is specially defined for church benefit purposes in IRC section 414(e)(3)(B) to ensure that all ministers of the faith, whether they are considered "employees" or "self-employed" for other tax purposes, are treated as employees of the plan sponsor (section attached). Thus arises the issue of whether church health plans are single-employer or multiple employer welfare arrangements (MEWAs).

Some state insurance commissioners have expressed concern that their state insurance statutes do not explicitly provide an exclusion for church plans, and that ERISA does not explicitly provide preemption treatment to these plans. Some commissioners have concurred that

Congress did not intend to subject church plans to more regulation than secular employer plans and have refrained from regulating them. Other states are pursuing statutory exemptions for church plans. Because of the clouded legal status of church plans, some managed care and other providers have been unwilling to contract with church plans.

The pending health insurance bills further confuse the situation. The House health insurance reform bill expands the current MEWA rules and offers church plans an election to obtain preemption from state insurance regulation if they are subjected to some, but not all, MEWA rules. This provision was part of the original Fawell bill as a result of the Alliance seeking to clarify that church plans should qualify for preemption treatment. The Senate bill treats these plans as "insurers" and "group health plans," without regard to the special operation of church plans provided in ERISA and the tax code.

The Alliance has not objected to the general thrust of the Senate bill. In fact their plans already operate to provide portability, and many plans already have policies that prevent denial of coverage. However, it is important to clarify that the church plans are not "insurance companies." They do not have the risk management tools that such companies have, and it would be impossible for most plans to register as insurance companies in each state in which they provide benefits (e.g., 50 states). If the church plans are going to be subject to the bill's provisions, then the law should be clarified to expressly grant them the preemption treatment other multi-state employers receive. Without the MEWA language in the Senate bill, with the legislative history of the House action, and the possibility that the broader House MEWA provisions may not be enacted, the church plans could face serious issues as to their status without such a clarification. It would be ironic if the result of the Senate insurance reform measure is to reduce coverage to church employees who are already benefitting from the types of coverage practices the bill is intended to require of all employers.

Attached is language that would serve the purpose of clarifying current law and the intention of the Senate bill. In essence the language maintains the status quo with respect to how these plans operate while subjecting them to the new access, portability, and renewability rules in the Senate bill. While the Alliance remains supportive of the Fawell church provision, the attached approach would address their concerns should the MEWA provisions not be adopted.

We look forward to seeing you next week.

## **The Church Alliance**

The Church Alliance is a coalition of church pension board executives acting on behalf of church pension and welfare benefit programs. These programs are among the oldest employee benefit programs in the United States. Several date from the 1700s, with the median age of the retirement programs represented through the Church Alliance being in excess of 50 years. These programs provide retirement and welfare benefits for approximately 261,000 ministers and 114,000 lay workers employed by thousands of churches and church ministry organizations. The 28 historic, mainline denominations served by these pensions boards minister to the spiritual needs of over 66 million members of Protestant and Jewish faiths.

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## CHURCH ALLIANCE

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### Steering Committee:

Mr. John G. Kapanke, Chair  
Mr. Alan F. Blanchard  
Ms. Barbara A. Boigegrain  
Ms. Joanne Brannick  
Mr. John J. Detterick  
Mr. James L. Hughes  
Mr. Leo J. Landes  
Mr. Dan A. Leeman  
Dr. Paul W. Powell  
Dr. Gordon E. Smith

### Members:

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Episcopal Church

Ms. Barbara A. Boigegrain  
United Methodist Church

Ms. Joanne Brannick  
The Pension Boards United Church of Christ

Mr. David J. Brown  
Reorganized Church of Jesus  
Christ of Latter Day Saints

Dr. L. Edward Davis  
Evangelical Presbyterian Church

Mr. John J. Detterick  
Presbyterian Church (U.S.A.)

Mr. William W. Evans  
National Association of Free Will Baptists

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Presbyterian Church in America

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Mr. Jeffrey A. Jenness  
Church of God

Mr. John G. Kapanke  
Evangelical Lutheran Church in America

Mr. Marlo J. Kauffman  
Mennonite Retirement Trust

Mr. Gary M. Kilgore  
Free Methodist Church of North America

Mr. Robert M. Koppel  
Rabbinical Pension Board

Mr. Leo J. Landes  
Joint Retirement Board of the Rabbinical  
Assembly

Mr. Dan A. Leeman  
The Lutheran Church-Missouri Synod

Rev. David Miller  
African Methodist Episcopal Zion Church

Rev. Wilfred E. Nolan  
Church of the Brethren

Dr. Lester D. Palmer  
Christian Church (Disciples of Christ)

Mr. Donald R. Pierson  
General Conference of Seventh-day  
Adventists

Rev. A. J. Poppen  
Reformed Church in America

Dr. Paul W. Powell  
Southern Baptist Convention

Dr. Darrell Prichard  
Churches of God, General Conference

Mr. David E. Provost  
Unitarian Universalist Association of  
Congregations in North America

Dr. Gordon E. Smith  
American Baptist Churches

Mr. Richard L. Sonntag  
Wisconsin Evangelical Lutheran Synod

Mr. Robert L. Temple  
Wesleyan Church

Dr. Anderson Todd, Jr.  
African Methodist Episcopal Church

Mr. Robert Van Stright  
Christian Reformed Church in North  
America

Rev. Don L. Walter  
Church of the Nazarene

Bro. William L. Walz, FSC  
Christian Brothers Services

**SEC. \_\_\_\_ SPECIAL RULE FOR CHURCH PLANS**

(a) **IN GENERAL.**—Neither a church plan (within the meaning of section 3(33) of the Employee Retirement Income Security Act of 1974) nor any trust established under such plan shall be deemed to be an insurance company or other insurer, or to be engaged in the business of insurance for purposes of, or be subject to, any law of any state purporting to regulate insurance companies, insurance contracts, multiple employer welfare arrangements, providers of third party administrative services, or other similar arrangements, providers or organizations. A church plan shall be deemed to be a single-employer plan for purposes of this section and for the purposes of ERISA.

(b) **EFFECTIVE DATE.**— This section shall be effective with respect to plans and trusts providing benefits on or after the date of enactment of this section.

## Code Sec. 414

1291

Act of 1935 or 1937 applies and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation by reason of the International Organizations Immunities Act (59 Stat. 669).

## [Sec. 414(e)]

## (e) CHURCH PLAN.—

(1) **IN GENERAL.**—For purposes of this part, the term "church plan" means a plan established and maintained (to the extent required in paragraph (2)(B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501.

(2) **CERTAIN PLANS EXCLUDED.**—The term "church plan" does not include a plan—

(A) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513); or

(B) if less than substantially all of the individuals included in the plan are individuals described in paragraph (1) or (3)(B) (or their beneficiaries).

(3) **DEFINITIONS AND OTHER PROVISIONS.**—For purposes of this subsection—

(A) **TREATMENT AS CHURCH PLAN.**—A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(B) **EMPLOYEE DEFINED.**—The term employee of a church or a convention or association of churches shall include—

(i) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation;

(ii) an employee of an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 and which is controlled by or associated with a church or a convention or association of churches; and

(iii) an individual described in subparagraph (E).

(C) **CHURCH TREATED AS EMPLOYER.**—A church or a convention or association of churches which is exempt from tax under section 501 shall be deemed the employer of any individual included as an employee under subparagraph (B).

(D) **ASSOCIATION WITH CHURCH.**—An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(E) **SPECIAL RULE IN CASE OF SEPARATION FROM PLAN.**—If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization described in clause (ii) of paragraph (3)(B), the church plan shall not fail to meet the requirements of this subsection merely because the plan—

(i) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(ii) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within the meaning of section 72(m)(7)) at the time of such separation from service.

(4) **CORRECTION OF FAILURE TO MEET CHURCH PLAN REQUIREMENTS.**—

(A) **IN GENERAL.**—If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 fails to meet one or more of the requirements of this subsection and corrects its failure to meet such requirements within the correction period, the plan shall be

Code § 414(e) ¶ 12,350

deemed to meet the requirements of this subsection for the year in which the correction was made and for all prior years.

(B) FAILURE TO CORRECT.—If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this subsection beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(C) CORRECTION PERIOD DEFINED.—The term "correction period" means—

(i) the period ending 270 days after the date of mailing by the Secretary of a notice of default with respect to the plan's failure to meet one or more of the requirements of this subsection;

(ii) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements, or, if the court does not specify such period, any reasonable period determined by the Secretary on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(iii) any additional period which the Secretary determines is reasonable or necessary for the correction of the default,

whichever has the latest ending date.

#### Amendments

P.L. 96-364, § 407(b):

Amended Code Sec. 414(e), effective January 1, 1974, to read as above. Prior to amendment, Code Sec. 414(e) read as follows:

"(e) CHURCH PLAN.—

"(1) IN GENERAL.—For purposes of this part the term 'church plan' means—

"(A) a plan established and maintained for its employees by a church or by a convention or association of churches which is exempt from tax under section 501, or

"(B) a plan described in paragraph (3).

"(2) CERTAIN UNRELATED BUSINESS OR MULTIEMPLOYER PLANS.—The term 'church plan' does not include a plan—

"(A) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513), or

"(B) which is a plan maintained by more than one employer, if one or more of the employers in the plan is not a

church (or a convention or association of churches) which is exempt from tax under section 501.

"(3) SPECIAL TEMPORARY RULE FOR CERTAIN CHURCH AGENCIES UNDER CHURCH PLAN.—

"(A) Notwithstanding the provisions of paragraph (2)(B), a plan in existence on January 1, 1974, shall be treated as a church plan if it is established and maintained by a church or convention or association of churches and one or more agencies of such church (or convention or association) for the employees of such church (or convention or association) and the employees of one or more agencies of such church (or convention or association), and if such church (or convention or association) and each such agency is exempt from tax under section 501.

"(B) Subparagraph (A) shall not apply to any plan maintained for employees of an agency with respect to which the plan was not maintained on January 1, 1974.

"(C) Subparagraph (A) shall not apply with respect to any plan for any plan year beginning after December 31, 1982."

#### [Sec. 414(f)]

(f) MULTIEMPLOYER PLAN.—

(1) DEFINITION.—For purposes of this part, the term "multiemployer plan" means a plan—

(A) to which more than one employer is required to contribute,

(B) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(C) which satisfies such other requirements as the Secretary of Labor may prescribe by regulation.

(2) CASES OF COMMON CONTROL.—For purposes of this subsection, all trades or businesses (whether or not incorporated) which are under common control within the meaning of subsection (c) are considered a single employer.

(3) CONTINUATION OF STATUS AFTER TERMINATION.—Notwithstanding paragraph (1), a plan is a multiemployer plan on and after its termination date under title IV of the Employee Retirement Income Security Act of 1974 if the plan was a multiemployer plan under this subsection for the plan year preceding its termination date.

(4) TRANSITIONAL RULE.—For any plan year which began before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980, the term "multiemployer plan" means a plan described in this subsection as in effect immediately before that date.

(5) SPECIAL ELECTION.—Within one year after the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980, a multiemployer plan may irrevocably elect, pursuant to

## Code Sec. 414

1291

Act of 1935 or 1937 applies and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation by reason of the International Organizations Immunities Act (59 Stat. 669).

## [Sec. 414(e)]

## (e) CHURCH PLAN.—

(1) **IN GENERAL.**—For purposes of this part, the term "church plan" means a plan established and maintained (to the extent required in paragraph (2)(B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501.

(2) **CERTAIN PLANS EXCLUDED.**—The term "church plan" does not include a plan—

(A) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513); or

(B) if less than substantially all of the individuals included in the plan are individuals described in paragraph (1) or (3)(B) (or their beneficiaries).

(3) **DEFINITIONS AND OTHER PROVISIONS.**—For purposes of this subsection—

(A) **TREATMENT AS CHURCH PLAN.**—A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(B) **EMPLOYEE DEFINED.**—The term employee of a church or a convention or association of churches shall include—

(i) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation;

(ii) an employee of an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 and which is controlled by or associated with a church or a convention or association of churches; and

(iii) an individual described in subparagraph (E).

(C) **CHURCH TREATED AS EMPLOYER.**—A church or a convention or association of churches which is exempt from tax under section 501 shall be deemed the employer of any individual included as an employee under subparagraph (B).

(D) **ASSOCIATION WITH CHURCH.**—An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(E) **SPECIAL RULE IN CASE OF SEPARATION FROM PLAN.**—If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization described in clause (ii) of paragraph (3)(B), the church plan shall not fail to meet the requirements of this subsection merely because the plan—

(i) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(ii) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within the meaning of section 72(m)(7)) at the time of such separation from service.

(4) **CORRECTION OF FAILURE TO MEET CHURCH PLAN REQUIREMENTS.**—

(A) **IN GENERAL.**—If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 fails to meet one or more of the requirements of this subsection and corrects its failure to meet such requirements within the correction period, the plan shall be

deemed to meet the requirements of this subsection for the year in which the correction was made and for all prior years.

(B) FAILURE TO CORRECT.—If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this subsection beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(C) CORRECTION PERIOD DEFINED.—The term "correction period" means—

(i) the period ending 270 days after the date of mailing by the Secretary of a notice of default with respect to the plan's failure to meet one or more of the requirements of this subsection;

(ii) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements, or, if the court does not specify such period, any reasonable period determined by the Secretary on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(iii) any additional period which the Secretary determines is reasonable or necessary for the correction of the default,

whichever has the latest ending date.

#### Amendments

P.L. 96-364, § 407(b):

Amended Code Sec. 414(e), effective January 1, 1974, to read as above. Prior to amendment, Code Sec. 414(e) read as follows:

"(e) CHURCH PLAN.—

"(1) IN GENERAL.—For purposes of this part the term 'church plan' means—

"(A) a plan established and maintained for its employees by a church or by a convention or association of churches which is exempt from tax under section 501, or

"(B) a plan described in paragraph (3).

"(2) CERTAIN UNRELATED BUSINESS OR MULTIEMPLOYER PLANS.—The term 'church plan' does not include a plan—

"(A) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513), or

"(B) which is a plan maintained by more than one employer, if one or more of the employers in the plan is not a

church (or a convention or association of churches) which is exempt from tax under section 501.

"(3) SPECIAL TEMPORARY RULE FOR CERTAIN CHURCH AGENCIES UNDER CHURCH PLAN.—

"(A) Notwithstanding the provisions of paragraph (2)(B), a plan in existence on January 1, 1974, shall be treated as a church plan if it is established and maintained by a church or convention or association of churches and one or more agencies of such church (or convention or association) for the employees of such church (or convention or association) and the employees of one or more agencies of such church (or convention or association), and if such church (or convention or association) and each such agency is exempt from tax under section 501.

"(B) Subparagraph (A) shall not apply to any plan maintained for employees of an agency with respect to which the plan was not maintained on January 1, 1974.

"(C) Subparagraph (A) shall not apply with respect to any plan for any plan year beginning after December 31, 1982."

#### [Sec. 414(f)]

(f) MULTIEMPLOYER PLAN.—

(1) DEFINITION.—For purposes of this part, the term "multiemployer plan" means a plan—

(A) to which more than one employer is required to contribute,

(B) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(C) which satisfies such other requirements as the Secretary of Labor may prescribe by regulation.

(2) CASES OF COMMON CONTROL.—For purposes of this subsection, all trades or businesses (whether or not incorporated) which are under common control within the meaning of subsection (c) are considered a single employer.

(3) CONTINUATION OF STATUS AFTER TERMINATION.—Notwithstanding paragraph (1), a plan is a multiemployer plan on and after its termination date under title IV of the Employee Retirement Income Security Act of 1974 if the plan was a multiemployer plan under this subsection for the plan year preceding its termination date.

(4) TRANSITIONAL RULE.—For any plan year which began before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980, the term "multiemployer plan" means a plan described in this subsection as in effect immediately before that date.

(5) SPECIAL ELECTION.—Within one year after the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980, a multiemployer plan may irrevocably elect, pursuant to

## MEMORANDUM

April 18, 1996

**TO:** Laura Tyson, Carol Rasco, Alice Rivlin, John Hilley, Alicia Munnell, Gene Sperling, Susan Brophy

**FR:** Chris Jennings, Jennifer Klein, and Nancy-Ann Min

**RE:** Insurance Reform Background Information

Attached are documents we prepared for today's Senate staff briefing on the Kassebaum-Kennedy bill and possible amendments to it. We prepared a short summary on each of the major issues and supplemented these summaries with back-up information. The briefing included materials on:

- The Health Insurance Reform Act: An Overview
- Multiple Employer Welfare Arrangements (MEWAs) Regulation
- Medical Savings Accounts (MSAs)
- Medical Liability Reform
- Fraud and Abuse Provisions
- Medigap Duplication

We hope you find this information useful. Please feel free to contact us with any questions.

**MEMORANDUM**

April 18, 1996

**TO:** Carol Rasco, Laura Tyson, John Hilley, Nancy-Ann Min, Susan Brophy, Jennifer Klein

**FR:** Chris Jennings

**RE:** Statement on MSAs

Attached are the prepared remarks we used following the 52-47 defeat of medical savings accounts (MSAs). Thought you might like to have these on hand.

**Today's vote against Medical Savings Accounts (MSAs) is a victory for the mainstream, a victory for bipartisanship, and -- most importantly -- a victory for the American public. It responds to the President's State of the Union call on the Congress to pass a long overdue package of much needed health insurance reforms. By defeating MSAs, the Senate took an important first step toward achieving this goal.**

**The Senate showed today that Democrats and Republicans can work together to pass health reform initiatives that reflect the priorities that the vast majority of Americans support. And that they can do so without insisting on controversial amendments that could hurt the health care delivery system and that have no broad-based support.**

**It is our hope that the upcoming conference will follow the Senate and report out a bill that can retain the bipartisan support that the Kassebaum-Kennedy bill currently has. We look forward to working with the conferees in the upcoming days and weeks to producing a bill that we all can proudly support.**

MEWA FILES



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444 N. Capitol Street, N.W., Suite 309  
Washington, D.C. 20001-1512  
202-624-7790

FAX 202-624-8579 Washington Counsel  
FAX 202-624-8460 Financial Analysis

National  
Association  
of Insurance  
Commissioners

March 28, 1996

Via Facsimile

The Honorable Newt Gingrich  
Speaker of the House  
H-232 Capitol Building  
Washington, DC 20515

Dear Mr. Speaker:

I am writing to comment upon the "Health Coverage Availability and Affordability Act of 1996", H.R. 3160, adopted by the House Rules Committee yesterday and scheduled for a vote by the full House of Representatives today. As you are aware, over the last few weeks, the National Association of Insurance Commissioners' (NAIC) Special Committee on Health Insurance (the "NAIC Committee"), together with the National Conference of State Legislatures ("NCSL"), has provided comments upon H.R. 995, H.R. 3063 and H.R. 3070.

We appreciate the legislation's extension of portability reforms to self-funded health care plans governed by the Federal Employee Retirement Income Security Act ("ERISA"); the NAIC has long called for these reforms and federal intervention in this area is laudable. We also appreciate certain clarifications that were made to provisions in the bills adopted by the committees of jurisdiction relating to state flexibility and the Medicare anti-duplication prohibitions. However, as detailed below, we continue to have serious concerns with the bill's provisions relating to multiple employer welfare arrangements ("MEWAs").

We commend the additional clarifications made within Title 1, Subtitle D, Section 192, relating to "State Flexibility to Provide Greater Protection". The bill contains further limits on the scope of its preemption than were contained in H.R. 3063 and H.R. 3070. The legislation now states that it does not preempt those state laws "that relate to matters not specifically addressed" in the bill. The bill also specifically saves several areas of state laws. We appreciate this enhanced state flexibility. We do, however, remain concerned about the absence of a broader construction clause explicitly saving from preemption any state laws that are not inconsistent with the bill and which provide greater beneficiary protection. In the absence of such a clause, the bill might be

The Honorable Newt Gingrich

March 28, 1996

Page two

construed to "preempt the field" of any state law that touches upon any area minimally mentioned in the bill, even if the bill's provisions were not intended to preempt such state law. Since this is a new area of federal intervention, we urge caution and care in the final crafting of preemption language.

We also appreciate the significant strides made in refining the range of health insurance policies which are not to be considered duplicative for the purposes of the application of the new Medicare anti-duplication provisions. We would appreciate the opportunity to clarify the states' remaining jurisdiction concerning health insurance policies governed by these provisions (possibly within legislative history) and to provide technical comments. We would like to commend you for tightening the consumer protections in these provisions from the earlier provisions adopted by amendment in committee.

We reiterate the concerns raised in our letter of March 18, 1996 to Chairmen Archer and Bliley concerning the long term care insurance related provisions within the legislation.

Unfortunately, we continue to have grave concerns that Subtitle C of Title 1 of H.R. 3160 would significantly erode existing state-level insurance reforms. The net effect of the final provisions relating to MEWAs is extremely damaging to states' authority to govern their own insurance market. The final language contains many layers of savings for, and exemptions from, state laws. This maze clouds the picture. Upon close examination of the multiple tiers of provisions, the bill preempts state laws governing health insurance, including those governing MEWAs, in all but a small number of states.

In sum, the changes made to Subtitle C do not represent a significant improvement from those contained within H.R. 995. We therefore remain opposed to most of the provisions contained within Subtitle C of Title I of the bill and reiterate the prior concerns expressed by the NAIC Committee on this topic. (See Joint NAIC Committee/NCSL letter dated March 5, 1996 to Representative William Goodling).

In addition, the bill still preempts state rating laws applicable to association plans thereby creating an unlevel playing field between these plans and other insured plans. Market fragmentation will thereby worsen and costs within the insured market could spiral. With respect to association plans, the bill also preempts state mandated benefit laws which have been enacted by the states.

The state budgetary impact of the bill is still likely to be significant. The bill only allows states to apply premium taxes to newly-formed or newly operating arrangements. Any arrangement that can argue they were already "operating" in a state cannot be taxed on a level playing field

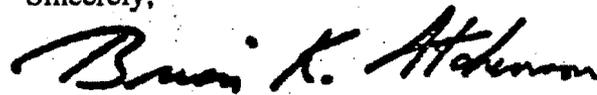
The Honorable Newt Gingrich  
March 28, 1996  
Page three

with state-regulated insurers. This provision thus promotes unfair competition and could significantly diminish state premium tax income.

The bill strips states of their oversight responsibility over a significant class of MEWAs. We question whether states could in good conscience accept responsibility for MEWA activities by asking the U.S. Department of Labor, pursuant to the option in the bill, for the authority to enforce the inadequate federal standards set forth in the bill. While gaps and ambiguities in federal law have led to some enforcement difficulties, this should be addressed by clarifications in federal law, not by the sweeping preemption of state regulatory authority over MEWAs proposed through H.R. 3160.

Thank you for your consideration of our comments. We look forward to continuing to work together on legislation to promote portability and availability of health insurance. Please feel free to call Kevin Cronin, the NAIC's Acting Executive Vice President and Washington Counsel at (202)-624-7790, with any questions you may have.

Sincerely,



Brian K. Atchinson  
President, NAIC  
Superintendent, Maine Bureau of Insurance

cc: The Honorable Bill Archer  
The Honorable Sam M. Gibbons  
The Honorable William F. Goodling  
The Honorable William L. Clay  
The Honorable Thomas J. Bliley  
The Honorable John D. Dingell

## PURCHASING COOPERATIVES AND MEWAs

### Background

Smaller businesses do not have the size or ability to negotiate lower prices and better arrangements in the health care market, as many larger employers have been able to do in recent years. Moreover, because of their size, premiums charged to smaller employers have higher marketing and administrative costs included. As a result small employers pay a substantially higher cost than large employers for comparable benefits.

- **Kassebaum-Kennedy Proposal**

To provide small employers with greater leverage in the health care market, the Kassebaum-Kennedy bill encourages the development of purchasing cooperatives. The bill would authorize states to certify as "purchasing cooperatives" entities that met certain conditions including: not bearing risk (i.e., they cannot self-insure), offering a range of products from different insurance carriers, and providing coverage on a first-come, first-served basis. State and employer participation would be voluntary.

- **Administration Position**

The Administration strongly supports the purchasing cooperative provisions of the Kassebaum-Kennedy proposal; it strongly opposes the MEWA provisions of the House bill, which some proponents argue serve the same purpose as the purchasing cooperatives.

### Issues

The primary reasons for supporting the purchasing cooperative provisions are:

- o **They permit small employers to band together to negotiate better rates because of their larger, collective size.**
- o **They are subject to state regulation and oversight.** Some MEWAs under the House bill would be exempt from state regulation and oversight and only be subject to weaker standards under ERISA.
- o **They would have to serve all eligible employers on a first-come, first-served basis.** Some MEWAs under the House bill would be able to "cherry-pick" the relatively good risks and leave the poorer risks--and thereby causing higher premium rates-- in the state insurance pool.
- o **Consumers are fully protected in purchasing cooperatives by state consumer protections standards (e.g., benefit claims dispute resolution) and guaranty funds.** Some MEWAs under the House bill would not be covered by a guaranty fund or adequate consumer protection requirements because they would be under ERISA.

- **Health plans offered through cooperatives would be subject to state solvency standards.** Some MEWAs under the House bill would only be subject to weaker standards under ERISA.

The purchasing cooperative provisions of Kassebaum-Kennedy build upon many years of state experience in regulating and overseeing health insurance and provide another means to the states for increasing coverage and lowering costs. The MEWA provisions in the House bill, however, would have almost the opposite effect: they would undermine the state regulatory system and make it more difficult for states to develop comprehensive state-wide reform.

## Summary of MEWA Cases

The following summaries are examples of MEWA-related cases investigated by the Department's Pension and Welfare Benefits Administration. Most criminal cases were jointly investigated with other agencies including the Department of Labor's Office of Labor Racketeering, the FBI, U. S. Postal Inspection Service, and the Internal Revenue Service's Criminal Investigative Division.

### Significant Criminal Cases

#### U. S. v. Sprei

**States Affected:** New York, New Jersey, and possibly others

**Thousands of participants of Empire Blue Cross/Blue Shield of New York were left with millions of dollars in unpaid medical claims as a result of a fraudulent health care scheme to bilk Empire and other insurers.** Solomon Sprei, a Brooklyn insurance broker, was charged January 19, 1996 with conspiracy, mail fraud, wire fraud, and bribery. Co-conspirator Timothy Neal, a benefit consultant with Empire, had been previously charged. The defendants led insurance companies to believe that applications for group health policies involved groups having histories of low health costs. Through a company Sprei owned, he sold coverage to individuals who the insurers thought were part of groups who had histories of low health costs. Victims were promised low-cost insurance under an "associate union membership" program. A union allowed him to use its name to market the insurance in exchange for a fee of \$14 per person per month. When Empire discovered that the health coverage was for mostly elderly, high-risk individuals, as opposed to members of a group, coverage was cancelled. Sprei then moved on to another insurer. Prosecution is ongoing.

#### U. S. v. Kirel & Marshall

**State Affected:** Arizona

**Approximately 3,500 participants in the health plan of the United Labor Council Local 615 were left with approximately \$4 million in unpaid medical claims as a result of a fraudulent health insurance scheme.** Carleton J. Kirel and Herbert M. Marshall were indicted for perpetrating the health insurance scheme. They were charged with mail fraud, conspiracy, money laundering and making false statements to a government agency. The defendants used the welfare plan of a purported labor union to market health insurance and workers' compensation insurance throughout the country. At the onset, funds were not set aside to pay benefit claims and premiums were used for various purposes unrelated to benefit claims, including the purchase of automobiles, mobile homes and vacation travel for their personal use. To conceal their criminal actions, they diverted some premiums through several bank accounts and entities.

Within a few months of its creation, the fund was insolvent. Despite the plan's inability to meet benefit claims, the defendants continued to solicit new participants until litigation in a related civil case brought by the Labor Department caused the appointment of an independent fiduciary to control the program. Prosecution is ongoing.

### U.S. v. Hay

**States Affected: California**

**One of the two health-insurance pools operated by Henry Hay went bankrupt in 1989, leaving thousands of workers without insurance and as much as \$6.6 million in unpaid health claims.** He was charged with paying portions of the \$17 million collected for premiums to two insurance executives who were charged as co-defendants in the kickback scheme. Hay represented to participating employers that health plans were fully insured when they were only partially insured for large claims. He was sentenced to five years in prison and three years of probation and ordered to make restitution of \$50,000. His sentence has been appealed. One of the insurance executives pled guilty and is awaiting sentencing. Charges against the other executive were dropped.

### U.S. v. Ullah

**States Affected: California, Arizona, Pennsylvania, Virginia, possibly others**

**At least 2,500 employers, representing approximately 4,000 workers are owed over \$3.2 million in unpaid health benefits in this ongoing case.** Hameed Ullah allegedly used 15 business-related entities, including United Health Benefits Trust, and 41 bank accounts to defraud employers and workers. The defendant refused to pay approved claims while continually telling workers and employers by mail and phone that claims would be paid. He was indicted for money laundering and asset forfeiture in connection with a fraudulent MEWA scheme. Nearly \$500,000 has been seized from accounts of Ullah. Two associates pled guilty in the scheme to making false statements and are awaiting sentencing.

### U.S. v. Hobbs

**States Affected: California**

**Subscribers were left with more than \$420,000 in unpaid claims and no insurance coverage when the health plan operated by Thomas Hobbs failed.** Most of the \$1,039,000 in premiums were diverted to salaries, commission and other administrative expenses, including more than \$400,000 paid directly to Hobbs or entities he controlled. He lured small businesses to purchase his group health insurance plans by making misleading

statements about benefits to be provided, size of his health insurance program, length of operation, financial strength, and his authority to operate outside state insurance laws and regulations. The defendant was sentenced to one year in prison, three years' probation, and was ordered to make restitution of \$201,000. He pled guilty in 1994 after being charged with embezzlement of health plan funds, making false statements in records required by ERISA and mail fraud.

### **U.S. v. Gazitua**

**States Affected: Florida**

**Described as one of the largest health insurance frauds in history, this health plan fraudulently collected more than \$34 million in health care premiums and cheated more than 40,000 workers out of more than \$29 million in medical claims.** John Gazitua and four co-defendants affiliated with now defunct International Forum of Florida Health Benefit Trust (IFFHBT) were charged with multiple violations of embezzlement of health funds, kickbacks, RICO, money laundering, criminal forfeiture, conspiracy, mail fraud and tax fraud.

Gazitua, a founder of IFFHBT, and the others allegedly skimmed money from premiums and created shell corporations to collect fees for nonexistent services. The court ordered Gazitua and a plan trustee to make over \$34 million in restitution and imposed prison terms of up to 97 months and home confinement for several of the defendants.

### **U.S. v. Felton**

**States Affected: Alabama, Kentucky, Pennsylvania, Tennessee, Virginia, West Virginia**

**This fraudulent MEWA operator, prosecuted in 1990 and 1991, left more than 2,500 participants with approximately \$2 million in unpaid claims.** Gary Felton, the former president of a North Carolina MEWA, was convicted of embezzling more than \$795,000 in MEWA funds. He was sentenced in 1991 to 10 years in prison. Cooperative efforts of federal and state insurance departments recovered \$587,257 to pay outstanding claims.

## Significant Civil Cases

### Reich v. Isely

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

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

A 1995 settlement recovered \$575,000 for participants from the defendants, insurance and other sources. As a result of these recoveries, the Department anticipates all claims below \$1,000 will be paid and certain claims of service providers may be reduced by 50-75%.

### Reich v. Dealers Association Plan

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

**Approximately 1,300 participants were left with approximately \$1 million in unpaid claims as a result of this failed MEWA. DAP, a plan service provider, contributed to the failure of the health plans by collecting insufficient premiums to pay both claims and anticipated administrative expenses. No actuarial studies were made, asset reserves were not maintained, and administrative expenses were excessive. The service provider also engaged in self-dealing through its receipt of commissions for the sale of life insurance.**

### Reich v. Wilhite

**States Affected: California, Arizona**

**About 1,500 participants in the Independent Automobile Dealers Association plan had about \$1 million in unpaid claims because the plan's assets were allowed to be depleted down to only \$150,000 through improper administration of the plan. The trustees of the plan committed numerous violations of ERISA when they maintained insufficient reserves in the MEWA, failed to set sound actuarial rates and paid excessive administrative expenses. Under consideration is a consent decree where the defendants would surrender the assets in the plan to a court-appointed trustee and a special master who would attempt to negotiate claims reductions with service providers. Under this agreement it is anticipated that the fiduciary insurance carrier**

(Aetna) will pay \$300,000 into the plan.

**Reich v. Jones**

**States Affected: Approximately 35 states, primarily Florida and Georgia**

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

**Reich v. Goebel**

**States Affected: California, New York**

**More than \$340,000 was recovered to pay benefits to approximately 1,200 participants and related administrative expenses in resolution of a civil lawsuit brought by the Department against plan fiduciaries Leo and Janice Goebel. The Goebels also were barred from involvement with ERISA plans. The defendants allegedly engaged in numerous ERISA violations in administering health plans of the National Council of Allied Employees LU 444. Local 444 purported to be a labor union, but conducted no union activities apart from the management and sale of employee benefits. The defendants failed to actuarially determine proper contribution rates, failed to hold plan assets in trust and dealt with plan assets for their own benefit.**

**Reich v. Hanson**

**States Affected: New York**

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

**Martin v. Kirel**

**States Affected: Arizona**

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

**Martin v. Beltz**

**Affected States: California, Texas and Florida**

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

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

**Affected States:**

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

### Martin v. Loeb

**Affected States: New York, Oklahoma, Florida**

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

### Martin v. Burton Goldstein

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

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

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

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

April 15, 1996

## Summary of MEWA Cases

The following summaries are examples of MEWA-related cases investigated by the Department's Pension and Welfare Benefits Administration. Most criminal cases were jointly investigated with other agencies including the Department of Labor's Office of Labor Racketeering, the FBI, U. S. Postal Inspection Service, and the Internal Revenue Service's Criminal Investigative Division.

### Significant Criminal Cases

#### U. S. v. Sprei

**States Affected: New York, New Jersey, and possibly others**

**Thousands of participants of Empire Blue Cross/Blue Shield of New York were left with millions of dollars in unpaid medical claims as a result of a fraudulent health care scheme to bilk Empire and other insurers.** Solomon Sprei, a Brooklyn insurance broker, was charged January 19, 1996 with conspiracy, mail fraud, wire fraud, and bribery. Co-conspirator Timothy Neal, a benefit consultant with Empire, had been previously charged. The defendants led insurance companies to believe that applications for group health policies involved groups having histories of low health costs. Through a company Sprei owned, he sold coverage to individuals who the insurers thought were part of groups who had histories of low health costs. Victims were promised low-cost insurance under an "associate union membership" program. A union allowed him to use its name to market the insurance in exchange for a fee of \$14 per person per month. When Empire discovered that the health coverage was for mostly elderly, high-risk individuals, as opposed to members of a group, coverage was cancelled. Sprei then moved on to another insurer. Prosecution is ongoing.

#### U. S. v. Kirel & Marshall

**State Affected: Arizona**

**Approximately 3,500 participants in the health plan of the United Labor Council Local 615 were left with approximately \$4 million in unpaid medical claims as a result of a fraudulent health insurance scheme.** Carleton J. Kirel and Herbert M. Marshall were indicted for perpetrating the health insurance scheme. They were charged with mail fraud, conspiracy, money laundering and making false statements to a government agency. The defendants used the welfare plan of a purported labor union to market health insurance and workers' compensation insurance throughout the country. At the onset, funds were not set aside to pay benefit claims and premiums were used for various purposes unrelated to benefit claims, including the purchase of automobiles, mobile homes and vacation travel for their personal use. To conceal their criminal actions, they diverted some premiums through several bank accounts and entities.

Within a few months of its creation, the fund was insolvent. Despite the plan's inability to meet benefit claims, the defendants continued to solicit new participants until litigation in a related civil case brought by the Labor Department caused the appointment of an independent fiduciary to control the program. Prosecution is ongoing.

### U.S. v. Hay

**States Affected: California**

**One of the two health-insurance pools operated by Henry Hay went bankrupt in 1989, leaving thousands of workers without insurance and as much as \$6.6 million in unpaid health claims.** He was charged with paying portions of the \$17 million collected for premiums to two insurance executives who were charged as co-defendants in the kickback scheme. Hay represented to participating employers that health plans were fully insured when they were only partially insured for large claims. He was sentenced to five years in prison and three years of probation and ordered to make restitution of \$50,000. His sentence has been appealed. One of the insurance executives pled guilty and is awaiting sentencing. Charges against the other executive were dropped.

### U.S. v. Ullah

**States Affected: California, Arizona, Pennsylvania, Virginia, possibly others**

**At least 2,500 employers, representing approximately 4,000 workers are owed over \$3.2 million in unpaid health benefits in this ongoing case.** Hameed Ullah allegedly used 15 business-related entities, including United Health Benefits Trust, and 41 bank accounts to defraud employers and workers. The defendant refused to pay approved claims while continually telling workers and employers by mail and phone that claims would be paid. He was indicted for money laundering and asset forfeiture in connection with a fraudulent MEWA scheme. Nearly \$500,000 has been seized from accounts of Ullah. Two associates pled guilty in the scheme to making false statements and are awaiting sentencing.

### U.S. v. Hobbs

**States Affected: California**

**Subscribers were left with more than \$420,000 in unpaid claims and no insurance coverage when the health plan operated by Thomas Hobbs failed.** Most of the \$1,039,000 in premiums were diverted to salaries, commission and other administrative expenses, including more than \$400,000 paid directly to Hobbs or entities he controlled. He lured small businesses to purchase his group health insurance plans by making misleading

statements about benefits to be provided, size of his health insurance program, length of operation, financial strength, and his authority to operate outside state insurance laws and regulations. The defendant was sentenced to one year in prison, three years' probation, and was ordered to make restitution of \$201,000. He pled guilty in 1994 after being charged with embezzlement of health plan funds, making false statements in records required by ERISA and mail fraud.

### **U.S. v. Gazitua**

**States Affected: Florida**

**Described as one of the largest health insurance frauds in history, this health plan fraudulently collected more than \$34 million in health care premiums and cheated more than 40,000 workers out of more than \$29 million in medical claims. John Gazitua and four co-defendants affiliated with now defunct International Forum of Florida Health Benefit Trust (IFFHBT) were charged with multiple violations of embezzlement of health funds, kickbacks, RICO, money laundering, criminal forfeiture, conspiracy, mail fraud and tax fraud.**

Gazitua, a founder of IFFHBT, and the others allegedly skimmed money from premiums and created shell corporations to collect fees for nonexistent services. The court ordered Gazitua and a plan trustee to make over \$34 million in restitution and imposed prison terms of up to 97 months and home confinement for several of the defendants.

### **U.S. v. Felton**

**States Affected: Alabama, Kentucky, Pennsylvania, Tennessee, Virginia, West Virginia**

**This fraudulent MEWA operator, prosecuted in 1990 and 1991, left more than 2,500 participants with approximately \$2 million in unpaid claims. Gary Felton, the former president of a North Carolina MEWA, was convicted of embezzling more than \$795,000 in MEWA funds. He was sentenced in 1991 to 10 years in prison. Cooperative efforts of federal and state insurance departments recovered \$587,257 to pay outstanding claims.**

## **Significant Civil Cases**

### **Reich v. Isely**

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

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

A 1995 settlement recovered \$575,000 for participants from the defendants, insurance and other sources. As a result of these recoveries, the Department anticipates all claims below \$1,000 will be paid and certain claims of service providers may be reduced by 50-75%.

### **Reich v. Dealers Association Plan**

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

**Approximately 1,300 participants were left with approximately \$1 million in unpaid claims as a result of this failed MEWA. DAP, a plan service provider, contributed to the failure of the health plans by collecting insufficient premiums to pay both claims and anticipated administrative expenses. No actuarial studies were made, asset reserves were not maintained, and administrative expenses were excessive. The service provider also engaged in self-dealing through its receipt of commissions for the sale of life insurance.**

### **Reich v. Wilhite**

**States Affected: California, Arizona**

**About 1,500 participants in the Independent Automobile Dealers Association plan had about \$1 million in unpaid claims because the plan's assets were allowed to be depleted down to only \$150,000 through improper administration of the plan. The trustees of the plan committed numerous violations of ERISA when they maintained insufficient reserves in the MEWA, failed to set sound actuarial rates and paid excessive administrative expenses. Under consideration is a consent decree where the defendants would surrender the assets in the plan to a court-appointed trustee and a special master who would attempt to negotiate claims reductions with service providers. Under this agreement it is anticipated that the fiduciary insurance carrier**

(Aetna) will pay \$300,000 into the plan.

**Reich v. Jones**

**States Affected: Approximately 35 states, primarily Florida and Georgia**

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

**Reich v. Goebel**

**States Affected: California, New York**

**More than \$340,000 was recovered to pay benefits to approximately 1,200 participants and related administrative expenses in resolution of a civil lawsuit brought by the Department against plan fiduciaries Leo and Janice Goebel.** The Goebels also were barred from involvement with ERISA plans. The defendants allegedly engaged in numerous ERISA violations in administering health plans of the National Council of Allied Employees LU 444. Local 444 purported to be a labor union, but conducted no union activities apart from the management and sale of employee benefits. The defendants failed to actuarially determine proper contribution rates, failed to hold plan assets in trust and dealt with plan assets for their own benefit.

**Reich v. Hanson**

**States Affected: New York**

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

**Martin v. Kirel**

**States Affected: Arizona**

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

**Martin v. Beltz**

**Affected States: California, Texas and Florida**

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

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

**Affected States:**

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

### Martin v. Loeb

**Affected States: New York, Oklahoma, Florida**

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

### Martin v. Burton Goldstein

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

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

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

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

April 15, 1996

## SUMMARY OF VICTIMS

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**U. S. Department of Labor**  
**April 16, 1996**

**Done Right Electric**  
**Kansas**

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

**Tri-State Trophy**  
**Mississippi**

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

**Androscoggin County Chamber of Commerce**  
**Maine**

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

**Sam's Bakery**  
**Maine**

Sam's Bakery leased employees from now-defunct Atlantic Staff Management. Atlantic is an employee leasing company based in Maine which sponsored a MEWA providing health and other benefits. The ERISA-covered MEWA was marketed to hundreds of small employers throughout **Maine and New Hampshire**. An employee of the bakery elected health coverage from the MEWA.

He incurred substantial medical bills after going in and out of the hospital for about a year with a bad back and broken neck. The MEWA failed to pay his medical expenses, thereby leaving him with outstanding medical bills of approximately \$28,000.

**Tulare County Bar Association  
California**

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

**California**

**J&S Enterprises**

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

\* \* \* \*

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