Approved March 22, 1983
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Chairman Rex Hoy at
Chairperson

3:30 ~~xxxx~~ a.m./p.m. on March 15, 1983 in room 521-S of the Capitol.

All members were present except:
Rep. Fuller, who was excused.

Committee staff present:
Wayne Morris, Legislative Research
Gordon Self, Revisor's Office
Mary Sorensen, Committee Secretary

Conferees appearing before the committee:
Dick Brock, Kansas Insurance Department
Stephen W. Robertson, Assistant Counsel, Health Insurance Association of America, Chicago, Illinois
Others present:
See List (Attachment 1)

Wayne Morris, of Legislative Research, gave a brief overview of SB 124, which was requested by the Insurance Department. Dick Brock, of the Insurance Department, then passed out Attachment 2, which is an article from the Wall Street Journal dated September 8, 1982, entitled "Ailing Insurers, Health Care Coverage for Many Small Firms Springs A Bad Leak". Chairman Hoy asked Wayne Morris to go on and explain SB 145 and then there would be further testimony and discussion on SB 124. Mr. Morris said SB 145 was also introduced at the request of the insurance department and concerned holding companies. The bill deletes provisions which allow the commissioner of insurance to disapprove a merger or other acquisition under the holding company act if approval would adversely affect the interests of security holders. Chairman Hoy asked Dick Brock if this wasn't taking away authority from the commissioner that might be helpful to stockholders. Mr. Brock answered that it was, but it was authority that was being challenged in many states in the courts, and the National Association of Insurance Commissioners thought this bill should be passed in order to avoid further court challenges. Mr. Brock said the insurance department was interested in policy holders, and there were other agencies who would take care of the security holders' interests.

SB 124 was then up for further consideration. Dick Brock said the bill dealt particularly with what is called multiple employer trusts (METs). These are insurance vehicles whereby several small employers will get together and develop an insurance plan, generally for health insurance, for their employees. They have generally worked pretty well, particularly where the employers procure insurance for their plan. In 1974, when ERISA came into law, it preempted state law for those plans which fell under its jurisdiction. However, it opened the door to abuse because any plan can "claim" to be approved by ERISA and then the insurance department cannot ask for any proof, and ERISA may never have heard of that particular plan. This bill would require that a certificate of some sort be shown to the department upon request, which shows the group is under the jurisdiction of some other state agency, or ERISA. If this evidence is not provided to the commissioner the insurance department then will have the authority to look into the plan to see if it falls under the regulations of the insurance department or if it is exempt. If it is not exempt, it can be examined for solvency. Mr. Brock said the other part of this bill is a disclosure section, which means that if it is an uninsured plan or a partially insured plan whoever is marketing that plan must disclose that information to the insureds. He asked the committee to read Attachment 2 to see what a problem uninsured plans had been in some places. He said he thought this bill would help, and there was no fiscal effect. Chairman Hoy asked if this bill would relate to HB 2255, which was passed out of this committee a few weeks ago, and Mr. Brock said that bill had no relation as these trusts, if they are not insurance companies, would fall under the Unauthorized Insurers Act, and one of the exemptions from that Act is group policies issued in another state.

Stephen W. Robertson, Assistant Counsel for the Health Insurance Association of America, then spoke on SB 124, and said this bill had been passed in California and Illinois. He said the original language, as the bill was introduced in the Senate, was almost the same as the language in those states, but the amendments that were made left out some key words, and their association was concerned. The words were "another state" on line 30. Mr. Robertson then gave an example of how a policy could be issued in one state for a large company, and

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that company might have some employees in Kansas. The company would have a master policy that complied with the insurance laws of the state in which it was issued, and the Kansas employees would be given certificates of insurance. The Kansas employees, being residents of Kansas, would be subject to the conditions and terms of the master policy, which might not be the same as Kansas requires. Mr. Robertson asked if this bill is intended to affect those master policies issued in another state to the degree that a certificate holder in the State of Kansas would receive benefits according to Kansas law, or according to the law of the state in which the master policy was written. He said if the bill isn't trying to affect the contract their organization supports it, but if it is trying to affect the benefits a Kansas resident would receive then he would like to speak further.

Dick Brock said this bill does not change the current exemptions. The department won't touch the certificates that are issued off a group policy in another state if that other state's laws are different. All it does is have a plan show the department their authority to be doing that business in this state, and if they can't do that it gives the department the authority to examine them. Rep. Spaniol asked if Dick Brock and the insurance department would support the amendment suggested by Mr. Robertson, to insert the words "another state", and Mr. Brock said they would not, and he did not think it was necessary in order to cover the situation Mr. Robertson was concerned about, as the present law was sufficient. Chairman Hoy said he thought the intent of the bill is not to police certificate coverages, but to allow the department to check for solvency and whether they are approved by ERISA. Mr. Brock said they did not really have any problem with these plans right now if they are insured by admitted companies, but the ones they have problems with are the ones insured by a non-admitted company or not insured at all--just a group of employers who have gone together and formed a company. Mr. Robertson said that, with Mr. Brock's explanation, he would not ask for the amendment, but he did want to make the point that it was a model law, and had been enacted by two states, California and Illinois, and both states had the words "another state" in their law.

Rep. Littlejohn moved that the minutes of February 28, March 1, March 2, and March 3, 1983, be approved, with correction of the spelling of Rep. Sutter's name. Rep. Spaniol seconded the motion. The motion carried.

The meeting adjourned at 4:20 PM.

GUEST LIST

COMMITTEE: House Insurance DATE: March 15, 1983

NAME	ADDRESS	COMPANY/ORGANIZATION
Stephen W. Robertson	332 South Michigan Ave Chicago, Illinois 60340	Health Insurance Association of America
Larry Magill	Topeka	IIAK
Ed Johnson	"	Kans. Life Assn.
Dick Brock	Topeka	Ins Dept
Al LeDoux	"	Majority Leaders Office

Atch. 1

WALL STREET JOURNAL, Wednesday, September 8, 1982 (pp.1 & 27)

Attachment 2

Ailing Insurers

Health Care Coverage For Many Small Firms Springs a Bad Leak

Trusts, Supposedly Regulated By U.S., Fail to Pay Bills Of Medical Policyholders

Regulatory No Man's Land

By Daniel Hertzberg
Staff Reporter of The Wall Street Journal

WESTMINSTER, Calif.—Roger Weaver, a 41-year-old California construction worker, has learned a painful lesson—that all medical insurance isn't the same.

When a series of illnesses and injuries piled up more than $11,000 in medical bills for his family recently, Mr. Weaver wasn't overly worried. Like millions of other Americans, he counted on his company health insurance to pick up the tab.

But Mr. Weaver's dream of security has become "a nightmare," he says. His bills have gone unpaid, and doctors and collection agencies have been hounding him for months. Last November, Mr. Weaver was taken to a local hospital for emergency treatment but was refused admittance because his earlier bills hadn't been paid. Although he finally was treated at another hospital, which accepted him, the experience has left him shaken.

When Mr. Weaver called his health insurer to correct the problem, he ran into a stone wall. "I was on the phone every day; they kept passing me from person to person," he says. "I threatened to sue them. It never bothered them."

Financial Provisions

Mr. Weaver's employer, like thousands of small businesses, had arranged for his health insurance with a special breed of health insurer, known as a multiple-employer trust, or MET. Unfortunately, a disproportionately large number of the hundreds of METs that have been set up across the country in recent years have run into financial difficulties.

The formation of METs got a big boost from the passage in 1974 of the Employee Retirement Income Security Act, or ERISA, which provided that employers can band together into groups to provide health benefits for their workers. As health-insurance costs have skyrocketed in recent years, thousands of small businesses have turned to METs as a means to match the cheap group-health-insurance benefits available to employees of large corporations.

Many of these new institutions, especially tailored for the needs of employees of smaller firms, seem to be doing the job they were intended to do and have aroused little criticism. This is particularly true, say state regulators, of METs that are underwritten by legitimate insurance companies.

Unpaid Bills

Too many METs, however, are "self-funded" or "self-insured" and are on shaky financial ground. Many seem to be get-rich schemes put together by skilled promoters who seek to profit from fees they charge to administer the trust. Others have run into trouble because they set unrealistically low rates in order to attract customers or failed to set aside sufficient reserves to cover future claims. As a result, they have left behind a mountain of unpaid bills, like Mr. Weaver's, and thousands of angry and bewildered policyholders.

Some examples:

—Since 1977, 45 METs that have done business in California have shut their doors. The biggest covered an estimated 20,000 people. Right now, "we know about half a dozen we think are in trouble," one California official says.

—Five METs have failed in Illinois. They include National Health Care Trust, which wrote insurance for over 5,000 employees of 82 Illinois nursing homes and Chai Erisa Trust, marketed to Jewish people.

—In Idaho, the Northwest Association of Independent Businesses is currently in liquidation; it has over $1 million in claims and $150,000 in assets, says the attorney for the court-appointed bankruptcy receiver.

—Arizona state regulators charge that some METs there are "hiring" legitimate insurers as fronts. Although the MET and the licensed insurer sign an insurance agreement, the policy, upon examination, doesn't commit the insurer to bear any financial risk.

Worried State Officials

Policyholders aren't the only ones who are angry over the situation. Worried state insurance commissioners say that the METs have been operating in a regulatory void, free of all the state controls that have been designed to protect policyholders. The federal ERISA legislation forbids states to regulate METS that qualify as employee benefit plans.

Meanwhile, enforcement efforts by the U.S. Labor Department, which has the responsibility to certify employee benefit plans, are woefully inadequate, state officials say. "What you have nationally is a house of cards," says former Illinois Insurance Director Philip O'Connor. "You are beginning to see it fall apart."

State regulators say that they often first hear about a MET when it is in trouble—and that is usually too late to help policyholders with unpaid bills.

When METs say they are federally regulated under ERISA rules, many states back off, although it is their traditional job to regulate insurance companies and perform periodic audits of their capital, reserves and other measures of financial health. But even when states persist, enforcement can be frustrating. Idaho officials say they battled for four years in court to establish state jurisdiction over the Northwest Association trust—until it finally went bankrupt. California Insurance Commissioner Robert C. Quinn warns, "We aren't in control, even though the public thinks we are."

If states can't regulate METs effectively, the federal government seemingly won't. The Labor Department "is ineffective and of little use in quickly controlling" troubled METs, says J. Michael Low, Arizona's director of insurance. States complain that the Labor Department is slow to rule on the eligibility of those METs that claim exemption from state control. States say that most METs don't meet ERISA standards, yet getting a federal ruling to this effect can take years.

Since 1974, the Labor Department has issued opinions on 41 METs; only five qualified as genuine employee benefit plans exempt from state regulation. Most METs that have gone bankrupt never received this Labor Department scrutiny, according to the National Association of Insurance Commissioners.

Federal officials admit that there's much truth to the states' complaints. "In all honesty, the federal government has screwed up" in some cases, says Jeffrey Clayton, the Labor Department's administrator of pension and welfare benefit programs. And he concedes that many MET operators "are just using ERISA as a dodge."

But Mr. Clayton says that MET are primarily a state concern, because few qualify as ERISA employee benefit plans. This summer he sent a letter to state insurance commissioners telling them to "assume that METs are covered by state law and proceed accordingly."

Meanwhile, several states have enacted state legislation to strengthen their control of METs, and the National Association of Insurance Commissioners has adopted a model bill for state enactment. The commissioners' group also is backing a bill in Congress that would let states set financial and solvency standards for METs.

Because METs exist in a no man's land between state and federal regulators, they pose special dangers for policyholders. Many states, for instance, have guaranty funds to protect policyholders in case their insurance company fails. But some state regulators say that METs don't qualify for guaranty-fund protection, because they aren't under state control.

The 'Rollover' Scheme

State regulators worry about the growing sophistication of unscrupulous MET operators. One phenomenon is the "rollover." This occurs when operators shut down a troubled MET, then reopen it, under a new name elsewhere. California's insurance department says it is aware of a trust that has rolled over five times in five different states.

In July, California's health-care industry suffered a jolt when the nation's biggest MET insolvency occurred there. The MET was the Continental Organization of Medical, Professional and Technical Employees, or COMPETE. It was forced into bankruptcy proceedings by a court-appointed receiver. Caught in the collapse were an estimated 20,000 small-business employees and their dependents, including Mr. Weaver and his family. The receiver believes that COM-

Att. 2

PETE and the company that ran it owe more than $15 million and have assets of only a few hundred thousand dollars.

COMPETE's major problems, according to state regulators, were premiums that were too low, excessive benefits and high administrative costs. At its peak last year, the big MET enrolled employees of 7,000 small businesses in California, Idaho and Colorado, and took in $1.8 million of premiums monthly, according to one former COMPETE administrator.

COMPETE's appeal to small businessmen was simple: health-care benefits at bargain rates. Policyholders were offered a "dual option" plan, which paid 100% of medical expenses if the policyholders used doctors and hospitals selected by the plan's administrators, and 80% of claims if they didn't.

Run by Outsiders

Like many METs, COMPETE was run by outsiders. Far West Administrators Inc. handled billing, claims payments and other functions. "The COMPETE trust did nothing. We did everything for them," says William L. Noble, an insurance agent who served as Far West's president in its final months.

COMPETE itself was an offshoot of another trust administered by Far West, the Western Conference Benefit Trust, a California health plan run by the Teamsters union and employers. The Western Conference fired Far West in early 1981 as the plan's administrator for unsatisfactory performance and "improper marketing," according to G. Oliver Brown, the Western Conference fund manager. Far West was owned by Nicholas Nicholson. Another key figure was Gordon Eldredge, the executive director of COMPETE. The California Insurance Department says it took away Mr. Eldredge's license to sell insurance last year in an unrelated case. Neither he nor Mr. Nicholson could be reached for comment.

Insiders say they knew COMPETE was on shaky financial ground from the start. For one thing, it had no reserves set aside to pay claims. "It was strictly cash flow," says Murray Rubin, who was the president of Far West for six months last year. Thus, claims could be paid only so long as cash was coming in the door.

Another problem was that almost half of the premiums paid by COMPETE policyholders weren't going to pay claims. Mr. Noble, Far West's last president, says that commissions to insurance agents, administrative fees to Far West and management fees to another Nicholson-owned company took 40% of the premiums. "The plan was actuarialy unsound," Mr. Noble says.

'Snowballing' Claims

The bottom line was that angry COMPETE policyholders found their claims weren't being paid. Calling Far West's office in Santa Ana, Calif., "was a major project," says policyholder Ronald Fuller, a sales engineer at California Gear & Instrument Co. "Sometimes you were on hold up to 45 minutes. Everyone was always out."

Unpaid claims "just kept snowballing," says James Thornton, a Pasadena, Calif., insurance agent who had placed the health coverage of eight organizations with COMPETE. "I begged it to call a meeting of all the brokers," he says, but to no avail.

One former Far West employee has told state investigators that in December 1981, Far West employees were told to stop paying COMPETE claims, with a few exceptions. But California officials charge that Far West's marketing arm continued selling the COMPETE plan well into this year without telling buyers that Far West wasn't paying the plan's claims.

Mr. Noble, who took over as president of Far West in February 1982, says he found "an incredible mess." Unpaid claims had risen to 26,000, he estimates. COMPETE, which had once enrolled 385 doctors and hospitals in its plan, had lost 85% of them because of nonpayment of claims. Queen of the Valley Hospital in West Covina, Calif., is one of the big losers; it says that Far West owes it more than $145,000. And the hospital is threatening to hold COMPETE patients liable for the money.

In March, Mr. Noble went to the California Insurance Department to discuss his company's problems. Shortly afterward, state officials filed suits, alleging licensing violations, among other things, against Far West and COMPETE. Subsequently, a state court named a receiver for the two firms. Since then, the receiver has filed petitions for Far West and COMPETE under Chapter 11 of the federal bankruptcy code, which protects a company from creditors while it tries to work out a plan to pay its debts.

'Knocking on the Doors'

The California Insurance Department says that Far West resisted state efforts to see the firm's records, asserting that COMPETE, as a MET, wasn't subject to state control. "We were knocking on the doors of Far West many months before we could shut them down," says Frank Damon, the chief deputy insurance commissioner.

Many of COMPETE and Far West's records are missing, state investigators say. However, Mr. Noble, the former Far West president, says, "From what I could see, everything was done within legal limits."

But state investigators aren't so sure. In the last couple of months before COMPETE's collapse, there don't appear to have been "any sizable payments" of premiums either to other insurers or to claimants, says Herbert G. Riggs, a state insurance investigator. Because financial records aren't available, "we would have to conclude that at least $1 million may have been used for purposes that wouldn't be consistent with the normal use of premiums in paying claims," he says. However, nobody has been charged with wrongdoing.

Some COMPETE policyholders will get their bills paid because COMPETE had an insurance contract with Kenesaw Life & Accident Insurance Co., an Atlanta-based insurer and unit of Lifesurance Corp. There were, in effect, at least two COMPETE trusts, one largely self-insured and the other insured by Kenesaw. Kenesaw says that between July 1981 and March 1982, it issued or assumed regular group-health-insurance policies covering 1,950 employers in COMPETE.

But most COMPETE policyholders don't know whether they will ever be paid. Linda Merrill, a secretary at a photographic firm, says she is swamped by $15,000 in unpaid medical bills she thought COMPETE would pay. "My back is against the wall," she says.