

AGENT TRAINING

UNAUTHORIZED INSURANCE ENTITIES

Major Regulatory Premise

State regulation of the business of insurance is in the public interest. The McCarran-Ferguson Act codified this premise into federal law in 1945.

Unauthorized Entities: Basic History, Overview, and Rationale

One of the main problem areas involving unauthorized insurance has been health insurance. However, unauthorized insurance has more recently invaded other lines, too, including workers compensation insurance.

While the insurance market has always been cyclical (hard and soft), the hard cycles have more recently spawned more fraudulent activity than seen in the past. Making matters worse, the perpetrators have become more sophisticated and have created more complex schemes.

Problems with unauthorized health-insuring entities started in earnest in or about 1974 with the enactment of the Employee Retirement Income Security Act, otherwise known as ERISA (29 U.S.C.A. 1001, et seq).

ERISA gave the United States Department of Labor responsibility for the enforcement of this body of statutory law. Within the Department of Labor, the Pension & Welfare Benefits Administration has direct involvement.

ERISA deals with employee health and welfare benefit plans. Stated differently, it deals with matters relating to employer-sponsored health-insurance-type plans, and with retirement plans. Insurance regulators' concern is with the health insurance aspect. *This material is limited to that aspect of ERISA.*

Rationale for regulatory concern with unauthorized insurance:

- Ongoing, not isolated, instances of such activity;
- Potential for criminal activity within the business of insurance;
- Adverse economic impact upon authorized insurers and other insurance licensees;
- Potential for large quantity of unpaid claims due to dishonesty and actuarial unsoundness;
- Absence of state or federal guaranty fund to cover unpaid claims;
- Adverse impact on future insurability of participants under statutes mandating guaranteed-issue health coverage (i.e., creditable coverage issue);
- Adverse economic impact upon health-care providers from unpaid claims;
- Lack of comprehensive federal oversight, including licensing and regulation similar to that of state insurance codes;
- Public perception that it is the role of state insurance regulators to protect them from illicit insurance schemes, to ensure that benefits are paid as contracted, and that legitimate insurance is available and affordable.

One of the goals of ERISA was to encourage individual employers to establish employee health plans. It did so, in part, by allowing the employers to fully *self-insure* the arrangements. That is, it allowed a *single employer* to establish a health plan *for that employer's employees and dependents*.

A self-insured plan is one in which the employer would itself, from its own funds, bear the financial responsibility for the covered health claims of its own participating employees. By self-insuring, the employer could make the benefits more affordable. This is because the employer would not incur the insurer's costs of doing business, including its profits, which are otherwise incorporated into the premium that would be charged for insurance coverage. Other such costs include maintaining statutory reserve requirements, regulatory compliance expenses, etc.

Alternatively, the employer could establish a *fully insured* health plan in which a *licensed insurer* would bear the financial risk for the payment of covered claims.

Particular Situations

“Union Plans” can be an exception to the MEWA definition (that is, not constitute a MEWA) and therefore, to the general rule of concurrent state and federal regulatory authority. However, for the exception to apply, the *U.S. Department of Labor must make an express finding* that the collective bargaining agreements between that union and the employers are bona fide. Absent such an express finding, the plan remains subject to state regulation as a MEWA.

“Association Plans” are not exempt from state insurance regulation for at least two reasons:

- There is *no* employer-employee relationship;
- They must be *fully insured* (therefore, at a minimum, the insurer is subject to regulation).

Professional Employer Organization (“PEO”) is the current nomenclature for what had been called an Employee Leasing Company. It presents special issues and has been targeted by purveyors of illicit insurance. Although there is purported to be a “co-employer” relationship established between the employer and the PEO, in reality, the PEO handles administrative functions, whereas the original employer continues to control the common law incidents of employment, such as:

- hiring and firing of employees;
- evaluation of employee performance;
- discipline;
- determining compensation;
- hours, location, nature, and method of the work to be performed.

A PEO-sponsored health plan is *not* exempt from state insurance regulation under ERISA for at least two reasons:

- There is no true employer/employee relationship between the employee and the PEO for the reasons stated above.
- Section 468.529(1), F.S., prohibits PEOs from sponsoring self-insured health plans. Because potential exemption from the Insurance Code arises only in the context of a fully self-insured plan, the exemption cannot exist with respect to a PEO-sponsored plan under current law.

If the PEO, or the purveyor of the supposed ERISA plan contends that each employer establishes its own, separate ERISA plan, it must be analyzed under the MEWA criteria stated above.

The keys:

- If there exists risk-bearing activity, including financial responsibility for the payment of claims of the employees and/or their dependents of two or more unrelated employers, the plan is a MEWA or an insurer, and is subject to state insurance licenses and regulation. Stated otherwise, the entity that is financially responsible for the payment of the resulting claims must be licensed by the Department of Financial Services.
- If there is commingling of funds of multiple unrelated employers, at any level (primary insurance, re-insurance, or stop-loss insurance), the plan is subject to state insurance regulation.

Possible Consequences for Aiding and Abetting an Unauthorized Insurer

- Conviction of a third-degree felony – 626.902(1), F.S.
- Liability for all unpaid claims – 626.901(2), F.S.
- Suspension or revocation of all insurance licenses – 626.621, F.S., 626.611, F.S., and 626.6215, F.S.

Possible Consequences for Acting as an Insurer without Proper License

- Conviction of a third-degree felony – 624.401, F.S.
- Liability for all unpaid claims – 626.901(2), F.S.
- Suspension or revocation of all insurance licenses – 626.621, F.S., 626.611, F.S., and 626.6215, F.S.