

**PREVENTION OF ILLEGAL MULTIPLE EMPLOYER  
WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL  
REGULATION**

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**Section 1. Statement of Purpose**

The purpose of this regulation is to prevent the operation of illegal health insurers, including illegal multiple employer welfare arrangements (MEWAs), in this state. This regulation states the law on this topic and establishes specific standards for persons and licensees who become aware of, or are asked to assist such an operation. This regulation is designed to require those persons and licensees to establish and follow responsible procedures to identify and report illegal health insurers. The department expects that compliance with this regulation will protect the public from entities offering fraudulent or otherwise illegal health care coverage.

**Drafting Note:** A state department adopting this regulation may wish to cite its statutory authority for adopting it. This regulation may be enacted under the authority of the NAIC Model Unauthorized Insurers Act. State statutes that are the equivalent to the following NAIC Model Acts may also provide authority to adopt some or all of the provisions of this regulation include:

- A. Section 19 of the NAIC Producer Licensing Model Act;
- B. Section 12 of the NAIC Unfair Trade Practices Act;
- C. Section 8 of the NAIC Unfair Claims Settlement Practices Act;
- D. Section 4B of the NAIC Third Party Administrator Statute;
- E. Section 3 of the NAIC Model Law on Examinations;
- F. NAIC Nonadmitted Insurance Model Act; or
- G. Section 12 of the NAIC Insurance Fraud Prevention Model Act.

**Section 2. Definitions**

- A. “Admitted insurer” means an insurer licensed to do an insurance business in this state [including an entity licensed as a multiple employer welfare arrangement (“licensed MEWA”), a health maintenance organization or nonprofit hospital or medical service corporation under the laws of this state].

**Drafting Note:** States that have a specific statutory licensing category “multiple employer welfare arrangements” (MEWAs) may wish to include the licensee within this definition. In addition, states that separately license health maintenance organizations or nonprofit hospital or medical service corporations should include these licensed entities within this definition.

- B. “Arrangement” means a fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits.
- C. “Department” means the insurance department of this state.

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- D. “Employee leasing arrangement” means a labor leasing, staff leasing, employee leasing, professional employer organization, contract labor, extended employee staffing or supply, or other arrangement, under contract or otherwise, whereby one business or entity represents that it leases or provides its workers to another business or entity.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some employee leasing arrangements to offer self-funded health benefit plans. Those states should take care to modify this regulation to reflect the applicable “professional employer organization” or “employee leasing” statutory structure

- E. “Employee welfare benefit plan” or “health benefit plan” means a plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.

- F. “Fully insured” means that for the health care benefits or coverage provided or offered by or through a health benefit plan or arrangement:

- (1) An admitted insurer is directly obligated by contract to each participant to provide all of the coverage under the plan or arrangement; and
- (2) The liability and responsibility of the admitted insurer to provide covered services or for payment of benefits is not contingent, and is directly to the individual employee, member or dependent.

- G. “Insurer” means [insert reference to appropriate state law].

- H. “Licensee” means a person that is, or that is required to be, licensed or registered under the laws of this state as a producer, third party administrator, insurer, employee leasing arrangement or preferred provider organization.

**Drafting Note:** A state should adjust the definition of “licensee” to reflect its licensing laws.

- I. “MEWA contact” means the individual or position designated by the department to be the MEWA contact as identified on the department web site.

**Drafting Note:** Every state is strongly encouraged to have an individual who is trained and knowledgeable about the application of state laws to MEWAs serve as the designated MEWA contact. In the event that a state does not designate such an individual to serve as the MEWA contact, reference should be made to the Department of Insurance instead of to the MEWA contact. States are encouraged to identify a specific MEWA contact on their web sites and in their relevant publications.

- J. “Non-admitted insurer” means an insurer not licensed to do an insurance business in this state.

- K. “Preferred provider organization” means an entity that engages in the business of offering a network of health care providers, whether or not on a risk basis, to employers, insurers or any other person who provides a health benefit plan.

- L. “Producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

- M. “Professional employer organization” means an arrangement, under contract or otherwise, whereby one business or entity represents that it co-employs or leases workers to another business or entity for an on-going and extended, rather than a temporary or project-specific, relationship

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this regulation to reflect that “professional employer organization” or “employee leasing” statutory structure

- N. “Third party administrator” or “administrator” has the meaning provided under [insert reference to the state’s third party administrator statute].

- O. “Transacting of insurance” means [insert reference to the state equivalent of Section 3P of the NAIC Nonadmitted Insurance Model Act] and includes:
- (1) Issuing a stop loss policy covering an employer located in this state. Stop loss policy coverage of an employer for claims incurred under the employer’s self-funded health benefit plan is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance;
  - (2) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, with an employer located in this state directly or indirectly the beneficiary of the trust;
  - (3) Agreeing to loan or advance funds to pay claims incurred under an employer’s self-funded health benefit plan if the availability of funds to advance is significantly dependent on payment of contributions and the claims experience of two or more employers who have entered into similar loan or advance agreements; or
  - (4) Engaging in a risk distribution arrangement providing for compensation of loss through the provision of services, including an arrangement established through marketing or representations to consumers, without specification in a contract.
- P. “Unauthorized health insurance” means:
- (1) Health insurance offered by a non-admitted insurer except to the extent the laws of this state allow the coverage to be offered by a non-admitted insurer licensed in another state through an employer or group located out of state; and
  - (2) includes health care benefits or coverage offered by a professional employer organization or an employee leasing arrangement that is not:
    - (a) Fully insured by an admitted insurer; or
    - [(b) Licensed or otherwise authorized under the laws of this state to offer a self-funded health benefit plan.]

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to include the optional bracketed language in this definition to reflect that statutory structure. The exception under Paragraph P (2) (b) is not intended to be adopted by states whose laws “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations unless those laws also include specific authority to self-fund a health benefit plan. Also, many states have laws that, under limited circumstances, permit a non-admitted insurer to provide coverage to a resident employer by an out of state employer or participating in an out of state group. Those states should modify this definition to reflect those provisions.

- (3) “Unauthorized health insurance” does not include:
  - (a) Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers (including one or more self-employed individuals), that is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.
  - (b) Health care benefits or coverage under an employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative as defined under 29 U.S.C. §1002(40)(B).
  - (c) Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers but only if the employers are within the same control group so the plan is deemed to be a single employer plan under 29 U.S.C. §1002(40)(B).
  - (d) Health care benefits or coverage under a church plan as defined under 29 U.S.C. §1002(33).

### Section 3. Licensee Reporting Requirement

- A. A licensee shall file a written report with the department MEWA contact when a licensee knows a product is, or is about to be, offered to the public in this state, and the licensee, based on the information known to the licensee, reasonably should know the product is unauthorized health insurance. Knowledge of a producer regarding an unrelated unauthorized health insurance arrangement is not imputed to licensed insurers represented by that producer.
- B. Circumstances where a licensee knows that a product is, or is about to be, offered to the public in this state, include when the licensee knows that any person is:
- (1) Recruiting producers to solicit or offer, or is soliciting or offering, a health benefit plan generally to the public in this state; or
  - (2) Seeking an administrator for, or is administering a health benefit plan that is intended to be offered generally to the public in this state.
- C. Circumstances where a licensee reasonably should know that a product is unauthorized health insurance include, but are not limited to, the following:
- (1) The licensee knows that the product is represented to be a self-funded plan and that it is offered widely to the multiple employers or generally to individuals.
  - (2) [The licensee knows that the product is a professional employer organization self-funded plan and that it is offered widely to multiple client employers.]

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to omit the optional bracketed language.

- (3) The licensee knows that the plan is represented to be a self-funded plan established or maintained pursuant to a collective bargaining agreement and that the plan is offered widely to multiple employers, or generally to individuals, or both, through agents who are compensated on a commission or similar basis.

**Drafting Note:** Paragraph C is not intended to be a comprehensive list of possible illegal schemes. It includes only a few of the most common illegal arrangements.

- D. (1) A report filed under this section is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] and shall not be subject to discovery or admissible in evidence in any private action. Nothing in this regulation shall limit the commissioner's authority to use a report filed pursuant to this regulation in the furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, determines to be necessary to further the purposes of this regulation.
- (2) Nothing in this regulation shall prevent or be construed as preventing the commissioner from disclosing the contents of a report filed under this section to the insurance department of any other state or agency of the federal government at any time, or any other regulatory or law enforcement agency provided the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this regulation. For reports filed under this section, [insert state law equivalent to Section 8 of the NAIC Insurance Fraud Prevention Act] applies.
- E. A report filed under this Section is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] except to the extent the commissioner determines disclosure is appropriate to accomplish a regulatory purpose.
- F. [There is immunity from civil liability under Section [insert state law equivalent to Section 7 A of the NAIC Insurance Fraud Prevention Act].]

**Drafting Note:** The NAIC recommends that states give serious consideration to seeking statutory authority to retain MEWA contact reports as confidential and to seeking statutory immunity from civil liability related to filing a MEWA contact report, absent a showing of actual malice, prior to adopting this regulation. Many states may already have such provisions enacted as part of the NAIC Insurance Fraud Prevention Act or similar legislation. Those states should include the optional bracketed language. Those states should take care to clarify that their insurance fraud prevention acts do not, or are amended so as to not, prevent the sharing of the reports within the department. States are also encouraged to use the model MEWA contact form the NAIC ERISA Working Group plans to develop.

- G. A licensee complies with this section if the licensee files the required report within thirty (30) days or a period reasonable under the circumstances, whichever is later.

#### **Section 4. Responsibility to Exercise Due Diligence**

##### **A. Soliciting Producer**

- (1) A producer, prior to engaging in or assisting any person to engage in offering a health benefit plan to an employer or person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:
  - (a) For any insurance coverage that is represented as issued relating to the health benefit plan:
    - (i) The insurer issued the policy;
    - (ii) The coverage is as represented;
    - (iii) The insurer is an admitted insurer in this state; and
    - (iv) The policy has been filed with, and approved by, the department or is exempt from filing requirements.
  - (b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.
  - (c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (c) should be revised if and to the extent, state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

- (d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

**Drafting Note:** Some states have a separate regulatory structure that recognizes a fully insured health plan of an employee leasing arrangement or professional employer organization as a single employer plan for certain regulatory purposes. Such a state should review Subparagraph (d) to ensure it conforms to such a provision.

B. Stop loss policy producer

- (1) A producer, prior to submitting an application for a stop loss policy to an insurer for a health benefit plan offered to employees, employee dependents, or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including measures reasonably appropriate to establish:
  - (a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.
  - (b) The health benefit plan that is not offered by an employee leasing arrangement or professional employer organization to client employers.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some employee leasing arrangements or professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (b) should be revised if and to the extent, state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

- (c) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

C. Third Party Administrator

- (1) A third party administrator, prior to entering into any administrative contract for a health benefit plan, and prior to assisting any person with administration of a health benefit plan, covering employees of an employer or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:
  - (a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:
    - (i) The insurer issued the policy;
    - (ii) The coverage is as represented;
    - (iii) The insurer is an admitted insurer in this state; and
    - (iv) The policy has been filed with, and approved by, the department or is exempt from filing requirements;
  - (b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.
  - (c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (c) should be revised if and to the extent, state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

- (d) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

D. Insurer

- (1) An insurer, prior to issuing a stop loss policy for a health benefit plan covering employees, employee dependents, or individuals located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:
  - (a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;
  - (b) The health benefit plan is not offered by an employee leasing arrangement or professional employer organization to client employers.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some employee leasing arrangements or professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (b) should be revised if and to the extent, state law authorizes an employee leasing arrangement or professional employer organization to self-fund a health benefit plan.

- (c) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.
- (2) An insurer shall not engage in the transacting of insurance by issuing a stop loss policy unless the insurer is an admitted insurer in this state and the stop loss policy form has been filed and approved by the department, or the form is exempt from filing. The transacting of insurance includes, but is not limited to:
  - (a) Issuing a stop loss policy covering an employer located in this state. Coverage of an employer for claims incurred under the employer’s self-funded health benefit plan with a stop loss policy is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance.
  - (b) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, when an employer located in this state is directly or indirectly the beneficiary of the trust.
- (3) An insurer shall not engage in the transacting of insurance in this state by issuing a stop loss policy unless, prior to issuing a contract for the stop loss policy, the insurer discloses clearly and conspicuously to the employer, in writing:
  - (a) The employer is not covered for claims below the stop loss attachment point;
  - (b) A description of the attachment point, including the specific and aggregate attachment points; and
  - (c) The insurer provides no other coverage of the employer’s retention.

E. Preferred provider organization

- (1) A preferred provider organization, prior to entering into any contract with a person offering or providing a health benefit plan in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:
  - (a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:
    - (i) The insurer issued the policy;
    - (ii) The coverage is as represented;
    - (iii) The insurer is an admitted insurer in this state; and
    - (iv) The policy has been filed with and approved by the department or is exempt from filing requirements;
  - (b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;
  - (c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (c) should be revised if and to the extent, state law authorizes an employee leasing arrangement or professional employer organization to self-fund a health benefit plan.

- (d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and dependents of employees, of the employer and the employer controls and directs the work of the employee.

F. (1) A licensee or other person who acts according to the written advice of the MEWA contact has a defense to any violation of this section if:

- (a) The information provided by the licensee or other person to the MEWA contact, to the extent material to the MEWA contact’s advice, is accurate and complete; and
- (b) The information is provided by the licensee or other person to the MEWA contact in writing.

- (2) For the purpose of this regulation, the department’s published list of admitted insurers on its web site is deemed to be accurate. A licensee or other person has a defense to any allegation that a listed insurer is not an admitted insurer. Nothing in this subsection relieves a licensee or other person from conducting due diligence to determine whether an entity is in fact the same entity as a listed admitted insurer.

**Drafting Note:** A state insurance department adopting this regulation is expected to publish, on the internet, a regularly updated list of admitted insurers.

- (3) A violation of this section is mitigated, and the department shall reduce or eliminate any sanction otherwise applicable, if a licensee or other person demonstrates all of the following:



- (a) It maintained supervisory procedures and controls that complied with Section 5;
  - (b) The violation occurred despite the maintenance of those procedures and controls;
  - (c) It promptly reported the health benefit plan to the MEWA contact once the licensee or other person had actual knowledge that it was unauthorized health insurance; and
  - (d) It took prompt corrective action.
- G. Nothing in this section requires a producer, third party administrator, insurer or preferred provider organization to conduct due diligence with respect to a health benefit plan that it is not assisting and with respect to which it does not engage in the transacting of insurance.

**Drafting Note:** This section requires producers, third party administrators, insurers, and preferred provider organization to exercise due diligence only to the extent that they assist or engage in the transacting of insurance relating to a health benefit plan. They are not required to investigate health benefit plans with respect to which they provide no services or transaction of insurance. For example, sale of a group life insurance policy does not require the selling producer or issuing agent to exercise due diligence as to the employer's health benefit plan.

### **Section 5. Supervisory Procedures and Controls**

- A. A producer, third party administrator, insurer, preferred provider organization or an agent of the same shall establish and maintain documented supervision procedures and controls that are reasonably designed to achieve compliance with this regulation.
- B. The supervisory procedures shall include:
  - (1) Training;
  - (2) Internal controls;
  - (3) Periodic audits;
  - (4) Supervisory review; and
  - (5) Monitoring and enforcement of contractual provisions established under Section 4 C and E.
- C. The extent of the supervisory procedures and controls a producer is required to maintain under this section may appropriately reflect the size and complexity of the producer's operations and the scope and nature of the producer's insurance activities.

**Drafting Note:** The NAIC encourages the national trade associations for health insurers, preferred provider organizations, third party administrators and insurance agents to develop compliance guidance, training and manuals to assist their members to implement supervisory procedures and controls. The NAIC ERISA Working Group is prepared to review the results of such an effort. State insurance departments are expected to give recognition to supervisory procedures and controls implemented by insurers, preferred provider organizations, third party administrators and insurance agents in accordance with guidance for effective programs developed by these trade organization. Companies also may seek review of their programs by their state insurance department.

### **Section 6. Licensing Education Requirements**

- A. A producer shall not be licensed in this state to sell health insurance unless the producer, prior to licensing, receives not less than one hour of education in:
  - (1) Identification of unauthorized health insurance; and
  - (2) The producer's responsibilities under this regulation.

**Drafting Note:** Subsection A would apply only to those states that have pre-licensing education requirements. The one-hour of education is intended to be included in, and not in addition to, the total pre-licensing requirement.

- B. An insurer providing health insurance in this state shall require its listed producers to obtain not less than one hour of continuing education every four years covering:
- (1) Identification of unauthorized health insurance; and
  - (2) The producer's responsibilities under this regulation.

**Drafting Note:** Subsection B should be adopted only by those states that have continuing education requirements. The one hour continuing education requirement should be included in the total hours required by the NAIC Producer Licensing Model Act.

- C. A third party administrator, preferred provider organization or insurer shall include in its application for a license a brief summary of its procedures and controls required under Section 5 in the [insert reference to the relevant statutory application requirement such as a statutory requirement to include a business plan]. A license may be denied under [insert reference to relevant statutory licensing criteria such as "contrary to the public interest"] if the applicant fails to demonstrate that the applicant maintains the required procedures and controls.

## **Section 7. Penalties and Liability**

- A. Except as provided in Subsection B, a person that violates this regulation is subject to [insert reference to general license and penalty provisions under the state insurance code, including the provisions equivalent to the remedy and penalty section of the NAIC Nonadmitted Insurance Model Act].

**Drafting Note:** The regulation should include a cross reference to penalty provisions equivalent to those in Section 7 of the NAIC Nonadmitted Insurance Model Act, as well as the remedial provision under Section 4D of that Act.

- B. A person who violates Section 3 of this regulation is subject to a penalty of a [forfeiture of up to \$1000] for each violation.

**Drafting Note:** A state insurance department should insert an appropriate penalty under the sanctions provided under its laws. Generally, a less severe penalty is appropriate compared to those for other violations under this regulation.

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*Chronological Summary of Action (all references are to the Proceedings of the NAIC)*

*2006 Proc. 2<sup>nd</sup> Quarter 40, 62-75 (adopted).*

**PREVENTION OF ILLEGAL MULTIPLE EMPLOYER  
WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL  
REGULATION**

The NAIC amended this model during the 2007 Summer National Meeting. These amendments were adopted as guidelines under the NAIC’s model laws process. The 2007 2<sup>nd</sup> Quarter Guideline Amendments are highlighted in grey.

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Appendix A	Reporting Form – Unauthorized MEWA or Health Coverage Program

**Section 1. Statement of Purpose**

The purpose of this regulation is to prevent the operation of illegal health insurers, including illegal multiple employer welfare arrangements (MEWAs), in this state. This regulation states the law on this topic and establishes specific standards for persons and licensees who become aware of, or are asked to assist such an operation. This regulation is designed to require those persons and licensees to establish and follow responsible procedures to identify and report illegal health insurers. The department expects that compliance with this regulation will protect the public from entities offering fraudulent or otherwise illegal health care coverage.

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**Section 2. Definitions**

- A. “Admitted insurer” means an insurer licensed to do an insurance business in this state [including an entity licensed as a multiple employer welfare arrangement (“licensed MEWA”), a health maintenance organization or nonprofit hospital or medical service corporation under the laws of this state].

**Drafting Note:** States that have a specific statutory licensing category “multiple employer welfare arrangements” (MEWAs) may wish to include the licensee within this definition. In addition, states that separately license health maintenance organizations or nonprofit hospital or medical service corporations should include these licensed entities within this definition.

- B. “Arrangement” means a fund, trust, plan, program or other mechanism by which a person provides, or attempts to provide, health care benefits.
- C. “Department” means the insurance department of this state.

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- D. “Employee leasing arrangement” means a labor leasing, staff leasing, employee leasing, professional employer organization, contract labor, extended employee staffing or supply, or other arrangement, under contract or otherwise, whereby one business or entity represents that it leases or provides its workers to another business or entity.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some employee leasing arrangements to offer self-funded health benefit plans. Those states should take care to modify this regulation to reflect the applicable “professional employer organization” or “employee leasing” statutory structure.

- E. “Employee welfare benefit plan” or “health benefit plan” means a plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.
- F. “Fully insured” means that for the health care benefits or coverage provided or offered by or through a health benefit plan or arrangement:
- (1) An admitted insurer is directly obligated by contract to each participant to provide all of the coverage under the plan or arrangement; and
  - (2) The liability and responsibility of the admitted insurer to provide covered services or for payment of benefits is not contingent, and is directly to the individual employee, member or dependent.
- G. “Insurer” means [insert reference to appropriate state law].
- H. “Licensee” means a person that is, or that is required to be, licensed or registered under the laws of this state as a producer, third party administrator, insurer, employee leasing arrangement or preferred provider organization.

**Drafting Note:** A state should adjust the definition of “licensee” to reflect its licensing laws.

- I. “MEWA contact” means the individual or position designated by the department to be the MEWA contact as identified on the department web site.

**Drafting Note:** Every state is strongly encouraged to have an individual who is trained and knowledgeable about the application of state laws to MEWAs serve as the designated MEWA contact. In the event that a state does not designate such an individual to serve as the MEWA contact, reference should be made to the Department of Insurance instead of to the MEWA contact. States are encouraged to identify a specific MEWA contact on their web sites and in their relevant publications.

- J. “Non-admitted insurer” means an insurer not licensed to do an insurance business in this state.
- K. “Preferred provider organization” means an entity that engages in the business of offering a network of health care providers, whether or not on a risk basis, to employers, insurers or any other person who provides a health benefit plan.
- L. “Producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.
- M. “Professional employer organization” means an arrangement, under contract or otherwise, whereby one business or entity represents that it co-employs or leases workers to another business or entity for an on-going and extended, rather than a temporary or project-specific, relationship.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this regulation to reflect that “professional employer organization” or “employee leasing” statutory structure.

- N. “Third party administrator” or “administrator” has the meaning provided under [insert reference to the state’s third party administrator statute].

- O. “Transacting of insurance” means [insert reference to the state equivalent of Section 3P of the NAIC Nonadmitted Insurance Model Act] and includes:
- (1) Issuing a stop loss policy covering an employer located in this state. Stop loss policy coverage of an employer for claims incurred under the employer’s self-funded health benefit plan is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance;
  - (2) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, with an employer located in this state directly or indirectly the beneficiary of the trust;
  - (3) Agreeing to loan or advance funds to pay claims incurred under an employer’s self-funded health benefit plan if the availability of funds to advance is significantly dependent on payment of contributions and the claims experience of two or more employers who have entered into similar loan or advance agreements; or
  - (4) Engaging in a risk distribution arrangement providing for compensation of loss through the provision of services, including an arrangement established through marketing or representations to consumers, without specification in a contract.
- P. “Unauthorized health insurance” means:
- (1) Health insurance offered by a non-admitted insurer except to the extent the laws of this state allow the coverage to be offered by an non-admitted insurer licensed in another state through an employer or group located out of state; and
  - (2) Includes health care benefits or coverage offered by a professional employer organization or an employee leasing arrangement that is not:
    - (a) Fully insured by an admitted insurer; or
    - [(b) Licensed or otherwise authorized under the laws of this state to offer a self-funded health benefit plan.]

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to include the optional bracketed language in this definition to reflect that statutory structure. The exception under Paragraph P (2) (b) is not intended to be adopted by states whose laws “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations unless those laws also include specific authority to self-fund a health benefit plan. Also, many states have laws that, under limited circumstances, permit a non-admitted insurer to provide coverage to a resident employer by an out of state employer or participating in an out of state group. Those states should modify this definition to reflect those provisions.

- (3) “Unauthorized health insurance” does not include:
  - (a) Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers (including one or more self-employed individuals), that is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.
  - (b) Health care benefits or coverage under an employee welfare benefit plan established or maintained by a rural electric cooperative or a rural telephone cooperative as defined under 29 U.S.C. §1002(40)(B).
  - (c) Health care benefits or coverage under an employee welfare benefit plan of the employees of two (2) or more employers but only if the employers are within the same control group so the plan is deemed to be a single employer plan under 29 U.S.C. §1002(40)(B).
  - (d) Health care benefits or coverage under a church plan as defined under 29 U.S.C §1002(33).

### Section 3. Licensee Reporting Requirement

- A. A licensee shall file a written report with the department MEWA contact when a licensee knows a product is, or is about to be, offered to the public in this state, and the licensee, based on the information known to the licensee, reasonably should know the product is unauthorized health insurance. Knowledge of a producer regarding an unrelated unauthorized health insurance arrangement is not imputed to licensed insurers represented by that producer.
- B. Circumstances where a licensee knows that a product is, or is about to be, offered to the public in this state, include when the licensee knows that any person is:
- (1) Recruiting producers to solicit or offer, or is soliciting or offering, a health benefit plan generally to the public in this state; or
  - (2) Seeking an administrator for, or is administering a health benefit plan that is intended to be offered generally to the public in this state.
- C. Circumstances where a licensee reasonably should know that a product is unauthorized health insurance include, but are not limited to, the following:
- (1) The licensee knows that the product is represented to be a self-funded plan and that it is offered widely to the multiple employers or generally to individuals.
  - (2) [The licensee knows that the product is a professional employer organization self-funded plan and that it is offered widely to multiple client employers.]

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to omit the optional bracketed language.

- (3) The licensee knows that the plan is represented to be a self-funded plan established or maintained pursuant to a collective bargaining agreement and that the plan is offered widely to multiple employers, or generally to individuals, or both, through agents who are compensated on a commission or similar basis.

**Drafting Note:** Paragraph C is not intended to be a comprehensive list of possible illegal schemes. It includes only a few of the most common illegal arrangements.

- D. (1) A report filed under this section is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] and shall not be subject to discovery or admissible in evidence in any private action. Nothing in this regulation shall limit the commissioner's authority to use a report filed pursuant to this regulation in the furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, determines to be necessary to further the purposes of this regulation.
- (2) Nothing in this regulation shall prevent or be construed as preventing the commissioner from disclosing the contents of a report filed under this section to the insurance department of any other state or agency of the federal government at any time, or any other regulatory or law enforcement agency provided the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this regulation. For reports filed under this section, [insert state law equivalent to Section 8 of the NAIC Insurance Fraud Prevention Act] applies.
- E. A report filed under this Section is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] except to the extent the commissioner determines disclosure is appropriate to accomplish a regulatory purpose.
- F. [There is immunity from civil liability under Section [insert state law equivalent to Section 7 A of the NAIC Insurance Fraud Prevention Act].]

**Drafting Note:** The NAIC recommends that states give serious consideration to seeking statutory authority to retain MEWA contact reports as confidential and to seeking statutory immunity from civil liability related to filing a MEWA contact report, absent a showing of actual malice, prior to adopting this regulation. Many states may already have such provisions enacted as part of the NAIC Insurance Fraud Prevention Act or similar legislation. Those states should include the optional bracketed language. Those states should take care to clarify that their insurance fraud prevention acts do not, or are amended so as to not, prevent the sharing of the reports within the department. States are also encouraged to use the model MEWA contact form the NAIC ERISA Working Group plans to develop.

- G. A licensee complies with this section if the licensee files the required report within thirty (30) days or a period reasonable under the circumstances, whichever is later.

#### **Section 4. Responsibility to Exercise Due Diligence**

##### **A. Soliciting Producer**

- (1) A producer, prior to engaging in or assisting any person to engage in offering a health benefit plan to an employer or person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:
  - (a) For any insurance coverage that is represented as issued relating to the health benefit plan:
    - (i) The insurer issued the policy;
    - (ii) The coverage is as represented;
    - (iii) The insurer is an admitted insurer in this state; and
    - (iv) The policy has been filed with, and approved by, the department or is exempt from filing requirements.
  - (b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.
  - (c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However Subparagraph (c) should be revised if and to the extent state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

- (d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.

**Drafting Note:** Some states have a separate regulatory structure that recognizes a fully insured health plan of an employee leasing arrangement or professional employer organization as a single employer plan for certain regulatory purposes. Such a state should review Subparagraph (d) to ensure it conforms to such a provision.

##### **B. Stop loss policy producer**

- (1) A producer, prior to submitting an application for a stop loss policy to an insurer for a health benefit plan offered to employees, employee dependents, or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including measures reasonably appropriate to establish:

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- (a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.
- (b) The health benefit plan that is not offered by an employee leasing arrangement or professional employer organization to client employers.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some employee leasing arrangements or professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However Subparagraph (b) should be revised if and to the extent state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

- (c) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.

C. Third Party Administrator

- (1) A third party administrator, prior to entering into any administrative contract for a health benefit plan, and prior to assisting any person with administration of a health benefit plan, covering employees of an employer or a person located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:
  - (a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:
    - (i) The insurer issued the policy;
    - (ii) The coverage is as represented;
    - (iii) The insurer is an admitted insurer in this state; and
    - (iv) The policy has been filed with, and approved by, the department or is exempt from filing requirements;
  - (b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40.
  - (c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However Subparagraph (c) should be revised if and to the extent state law authorizes an employee leasing arrangement to self-fund a health benefit plan.

- (d) For any health benefit plan that is represented as established by a single employer, that the health benefit plan is covering solely employees and their dependents, and the employer controls and directs the work of the employee.



D. Insurer

- (1) An insurer, prior to issuing a stop loss policy for a health benefit plan covering employees, employee dependents, or individuals located in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:
  - (a) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;
  - (b) The health benefit plan is not offered by an employee leasing arrangement or professional employer organization to client employers .

**Drafting Note:** Some states have a separate regulatory structure that authorizes some employee leasing arrangements or professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (b) should be revised if and to the extent state law authorizes an employee leasing arrangement or professional employer organization to self-fund a health benefit plan.

- (c) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.
- (2) An insurer shall not engage in the transacting of insurance by issuing a stop loss policy unless the insurer is an admitted insurer in this state and the stop loss policy form has been filed and approved by the department, or the form is exempt from filing. The transacting of insurance includes, but is not limited to:
  - (a) Issuing a stop loss policy covering an employer located in this state. Coverage of an employer for claims incurred under the employer’s self-funded health benefit plan with a stop loss policy is insurance, not reinsurance, regardless of whether the contract is described by the insurer as reinsurance.
  - (b) Issuing a stop loss policy to a trust or trustee, whether the trust or trustee is located in this state or otherwise, when an employer located in this state is directly or indirectly the beneficiary of the trust.
- (3) An insurer shall not engage in the transacting of insurance in this state by issuing a stop loss policy unless, prior to issuing a contract for the stop loss policy, the insurer discloses clearly and conspicuously to the employer, in writing:
  - (a) The employer is not covered for claims below the stop loss attachment point;
  - (b) A description of the attachment point, including the specific and aggregate attachment points; and
  - (c) The insurer provides no other coverage of the employer’s retention.

E. Preferred provider organization

- (1) A preferred provider organization, prior to entering into any contract with a person offering or providing a health benefit plan in this state, shall carry out appropriate due diligence to establish that the health benefit plan is not unauthorized health insurance, including those measures reasonably appropriate to establish:
  - (a) Through initial inquiry, contract provisions and measures to monitor and enforce compliance with the contract provisions, that for any insurance coverage that is represented as issued relating to the health benefit plan:

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- (i) The insurer issued the policy;
  - (ii) The coverage is as represented;
  - (iii) The insurer is an admitted insurer in this state; and
  - (iv) The policy has been filed with and approved by the department or is exempt from filing requirements;
- (b) For any health benefit plan that is represented as established or maintained pursuant to a collective bargaining agreement, the health benefit plan is established or maintained under or pursuant to a collective bargaining agreement under the criteria provided under 29 CFR 2510.3-40;
- (c) For any health benefit plan that is represented as established or maintained by an employee leasing arrangement or professional employer organization, the health benefit plan is fully insured.

**Drafting Note:** Some states have a separate regulatory structure that authorizes some professional employer organizations to self-fund health benefit plans. Those states should take care to modify this section to reflect that statutory structure. This does not include state laws that “register” or otherwise “authorize” employee leasing arrangements or professional employer organizations absent specific authority to self-fund a health benefit plan. However, Subparagraph (c) should be revised if and to the extent state law authorizes an employee leasing arrangement or professional employer organization to self-fund a health benefit plan.

- (d) For any health benefit plan that is represented as established by a single employer, the health benefit plan is covering solely employees, and dependents of employees, of the employer and the employer controls and directs the work of the employee.
- F. (1) A licensee or other person who acts according to the written advice of the MEWA contact has a defense to any violation of this section if:
- (a) The information provided by the licensee or other person to the MEWA contact, to the extent material to the MEWA contact’s advice, is accurate and complete; and
  - (b) The information is provided by the licensee or other person to the MEWA contact in writing.
- (2) For the purpose of this regulation the department’s published list of admitted insurers on its web site is deemed to be accurate. A licensee or other person has a defense to any allegation that a listed insurer is not an admitted insurer. Nothing in this subsection relieves a licensee or other person from conducting due diligence to determine whether an entity is in fact the same entity as a listed admitted insurer.

**Drafting Note:** A state insurance department adopting this regulation is expected to publish, on the internet, a regularly updated list of admitted insurers.

- (3) A violation of this section is mitigated, and the department shall reduce or eliminate any sanction otherwise applicable, if a licensee or other person demonstrates all of the following:
- (a) It maintained supervisory procedures and controls that complied with Section 5;
  - (b) The violation occurred despite the maintenance of those procedures and controls;
  - (c) It promptly reported the health benefit plan to the MEWA contact once the licensee or other person had actual knowledge that it was unauthorized health insurance; and
  - (d) It took prompt corrective action.

- G. Nothing in this section requires a producer, third party administrator, insurer or preferred provider organization to conduct due diligence with respect to a health benefit plan that it is not assisting and with respect to which it does not engage in the transacting of insurance.

**Drafting Note:** This section requires producers, third party administrators, insurers, and preferred provider organization to exercise due diligence only to the extent that they assist or engage in the transacting of insurance relating to a health benefit plan. They are not required to investigate health benefit plans with respect to which they provide no services or transaction of insurance. For example, sale of a group life insurance policy does not require the selling producer or issuing agent to exercise due diligence as to the employer's health benefit plan.

## **Section 5. Supervisory Procedures and Controls**

- A. A producer, third party administrator, insurer, preferred provider organization or an agent of the same shall establish and maintain documented supervision procedures and controls that are reasonably designed to achieve compliance with this regulation.
- B. The supervisory procedures shall include:
  - (1) Training;
  - (2) Internal controls;
  - (3) Periodic audits;
  - (4) Supervisory review; and
  - (5) Monitoring and enforcement of contractual provisions established under Section 4 C and E.
- C. The extent of the supervisory procedures and controls a producer is required to maintain under this section may appropriately reflect the size and complexity of the producer's operations and the scope and nature of the producer's insurance activities.

**Drafting Note:** The NAIC encourages the national trade associations for health insurers, preferred provider organizations, third party administrators and insurance agents to develop compliance guidance, training and manuals to assist their members to implement supervisory procedures and controls. The NAIC ERISA Working Group is prepared to review the results of such an effort. State insurance departments are expected to give recognition to supervisory procedures and controls implemented by insurers, preferred provider organizations, third party administrators and insurance agents in accordance with guidance for effective programs developed by these trade organization. Companies also may seek review of their programs by their state insurance department.

## **Section 6. Licensing Education Requirements**

- A. A producer shall not be licensed in this state to sell health insurance unless the producer, prior to licensing, receives not less than one hour of education in:
  - (1) Identification of unauthorized health insurance; and
  - (2) The producer's responsibilities under this regulation.

**Drafting Note:** Subsection A would apply only to those states that have pre-licensing education requirements. The one-hour of education is intended to be included in, and not in addition to, the total pre-licensing requirement.

- B. An insurer providing health insurance in this state shall require its listed producers to obtain not less than one hour of continuing education every four years covering:
  - (1) Identification of unauthorized health insurance; and
  - (2) The producer's responsibilities under this regulation.

**Drafting Note:** Subsection B should be adopted only by those states that have continuing education requirements. The one hour continuing education requirement should be included in the total hours required by the NAIC Producer Licensing Model Act.

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- C. A third party administrator, preferred provider organization or insurer shall include in its application for a license a brief summary of its procedures and controls required under Section 5 in the [insert reference to the relevant statutory application requirement such as a statutory requirement to include a business plan]. A license may be denied under [insert reference to relevant statutory licensing criteria such as “contrary to the public interest”] if the applicant fails to demonstrate that the applicant maintains the required procedures and controls.

**Section 7. Penalties and Liability**

- A. Except as provided in Subsection B, a person that violates this regulation is subject to [insert reference to general license and penalty provisions under the state insurance code, including the provisions equivalent to the remedy and penalty section of the NAIC Nonadmitted Insurance Model Act].

**Drafting Note:** The regulation should include a cross reference to penalty provisions equivalent to those in Section 7 of the NAIC Nonadmitted Insurance Model Act, as well as the remedial provision under Section 4D of that Act.

- B. A person who violates Section 3 of this regulation is subject to a penalty of a [forfeiture of up to \$1000] for each violation.

**Drafting Note:** A state insurance department should insert an appropriate penalty under the sanctions provided under its laws. Generally a less severe penalty is appropriate compared to those for other violations under this regulation.

## **APPENDIX A**

### **REPORTING FORM – UNAUTHORIZED MEWA OR HEALTH COVERAGE PROGRAM**

Pursuant to [insert reference to state equivalent to Prevention of Unauthorized Multiple Employer Welfare Arrangements (MEWAs) and Other Unauthorized Insurers Model Regulation], licensees are required to file a written report with the [insert name and title of state insurance department MEWA contact] when a licensee knows a product is, or is about to be, offered to the public in this state, and the licensee, based on the information known to the licensee, reasonably should know the product is unauthorized health insurance. This form may be used by persons and licensees seeking to comply with these requirements.

Please answer all questions as fully as possible.

#### **LICENSEE IDENTIFICATION INFORMATION**

1. Name of Licensee making report:

2. Address of Licensee:

3. Type of Licensee (Check all that apply):

Producer

Third Party Administrator

Insurer (List Type of Insurer, i.e. Health, HMO, Stop Loss, Life...)

Employee Leasing Arrangement

Preferred Provider Organization

Other: \_\_\_\_\_

**Drafting Note:** States should modify the list of licensees to include all persons that are required to be licensed or registered under the insurance laws of this state or other laws administered by the insurance department.

4. Name, address and phone number of representative(s) of the Licensee who can answer follow up questions.

#### **UNAUTHORIZED ENTITY INFORMATION**

5. Please describe the product that is, or is about to be offered to the public in this state, including the name of the product and the name(s) and all contact information you have for person(s) associated with the product (i.e., direct insurers, stop loss insurers, third party administrators, pharmacy benefit managers, and preferred provider organizations).

6. When and how did you learn about this product and that this product is, or is about to be, offered? To the extent possible, please provide a timeline of your interactions with the persons involved with this product. Please include the date when you first became aware of this product and the date of your last interaction with the persons involved with this product.

7. What information led you to conclude that you reasonably should know the product is unauthorized health insurance. Please check any of the descriptions listed below that apply and include as much detailed information as you can in the explanation section. Please attach any external documentation that you have regarding the plan or product that is the subject of this report (i.e., webpage printouts, marketing materials, application forms, insurance policies, and enrollee materials).

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- A. The plan was represented as being insured, but misrepresented one or more of the following (check all that apply):

The insurer that issued the policy  
The coverage that was represented  
The status of the insurer as an admitted insurer in this state  
That the policy has been filed with, and approved by, the department.  
That the policy is exempt from filing requirements

Additional Explanation:

- B. The plan was represented as being established or maintained pursuant to a collective bargaining agreement but fails to meet the criteria provided under 29 CFR 2510.3-40 as being established or maintained pursuant to a collective bargaining agreement.

Additional Explanation:

- C. The plan was represented as being a self-funded plan established or maintained pursuant to a collective bargaining agreement and the plan is offered widely to multiple employers, or generally to individuals, or both, through agents who are compensated on a commission or similar basis.

Additional Explanation:

- D. The product was represented as being a single employer self-funded plan and is offered widely to multiple employers or generally to individuals.

Additional Explanation:

- E. The product was represented as being a self-funded employee leasing arrangement plan or self-funded professional employer organization plan.

Additional Explanation:

**Drafting Note:** Some states have a separate regulatory structure that authorizes some employee leasing companies or professional employer organizations to self-fund health benefit plans. Those states should modify E to conform with state law. For example, state law may impose specific conditions upon a professional employer organization's ability to self-insure. In those cases, a company operating outside those conditions or requirements should be reported.

- F. The plan was represented as established by a single employer, but is extending coverage beyond the employees and dependents of the employees of the employer or the employer does not control and direct the work of the employees.

- G. The product involves the use of stop loss insurance issued to a trust or trustee with the employer as the direct or indirect beneficiary of the trust.

Additional Explanation:

- H. The product involves the use of stop loss insurance that is characterized as reinsurance.

Additional Explanation:

- I. The product involves the use of stop loss insurance issued by an insurer that is not admitted in this state or uses a policy form that has not been filed and approved by the insurance department.

Additional Explanation:

- J. Other information that led you to conclude that you reasonably should know the product is unauthorized health insurance.

**Additional Explanation:**

8. Have you heard that this product may be, or is about to be offered in any other states? Name those states, if possible.

**CONFIDENTIALITY NOTICE AND NOTICE OF FURTHER DISCLOSURE**

This reporting form and any information submitted on this reporting form is confidential and privileged from disclosure in response to a subpoena or otherwise under [insert statutory cite for authority to keep these reports confidential and privileged] and shall not be subject to discovery or admissible in evidence in a private action. There is immunity from civil liability related to filing this report, absent a showing of actual malice, pursuant to [insert state law equivalent to Section 7A of the NAIC Insurance Fraud Prevention Act].

The insurance commissioner retains authority to use this report in furtherance of any legal or regulatory action that the commissioner, in the commissioner's sole discretion, determines to be necessary to further the purpose of preventing the operation of illegal health insurers, including illegal Multiple Employer Welfare Arrangements, in this state.

The insurance commissioner may disclose the contents of this report to the insurance department of any other state or agency of the federal government at any time, or any other regulatory or law enforcement agency, provided the agency or office receiving the report or matter relating thereto agrees to hold it confidential in a manner consistent with [insert reference to state equivalent to Prevention of Unauthorized Multiple Employer Welfare Arrangements (MEWAs) and Other Unauthorized Insurers Model Regulation]. This report is subject to [insert state law equivalent to Section 8 of the NAIC Insurance Fraud Prevention Act.]

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*Chronological Summary of Actions (All references are to the Proceedings of the NAIC).*

*2006 Proc. 2<sup>nd</sup> Quarter 40, 62-75 (original model adopted).*

*2007 Proc. 2<sup>nd</sup> Quarter Vol. I 129, 133, 211-215 (guideline amendments adopted).*

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**PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER  
ILLEGAL HEALTH INSURERS MODEL REGULATION**

**This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.**

**This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.**

**PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER  
ILLEGAL HEALTH INSURERS MODEL REGULATION**

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**PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER ILLEGAL HEALTH INSURERS MODEL REGULATION**

**KEY:**

**MODEL ADOPTION:** States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

**RELATED STATE ACTIVITY:** Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

**NO CURRENT ACTIVITY:** No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO CURRENT ACTIVITY	
Alaska		ALASKA STAT. § 21.85.100 (2010); BULLETIN 83-8 (1983).
American Samoa	NO CURRENT ACTIVITY	
Arizona		Circular Letter 92-5 (1992) (Joint state/federal statement).
Arkansas	NO CURRENT ACTIVITY	
California		CAL. INS. CODE § 742.245 (2008/2012).
Colorado		4 COLO. CODE REGS. § 2-10 (1994/2006).
Connecticut		CONN. AGENCIES REGS. §§ 38a-272-1 to 38a-272-10 (1992/2013); BULLETIN N HC-32 (1983).
Delaware	NO CURRENT ACTIVITY	
District of Columbia	NO CURRENT ACTIVITY	

**PREVENTION OF ILLEGAL MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) AND OTHER  
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<b>NAIC MEMBER</b>	<b>MODEL ADOPTION</b>	<b>RELATED STATE ACTIVITY</b>
Florida	NO CURRENT ACTIVITY	
Georgia		GA. CODE ANN. § 33-50-2 (2009); § 33-50-14 (2010).
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho	NO CURRENT ACTIVITY	
Illinois	NO CURRENT ACTIVITY	
Indiana		760 IND. ADMIN. CODE 1-68-1 to 1-68-19 (2007/2009); BULLETIN 65 (1990).
Iowa	NO CURRENT ACTIVITY	
Kansas		BULLETIN 1991-21 (1991).
Kentucky	NO CURRENT ACTIVITY	
Louisiana	NO CURRENT ACTIVITY	
Maine	NO CURRENT ACTIVITY	
Maryland	NO CURRENT ACTIVITY	
Massachusetts	NO CURRENT ACTIVITY	
Michigan		BULLETIN 79-19 (1979).
Minnesota		MINN. STAT. §§ 62H.11 to 62H.17 (1994).
Mississippi	NO CURRENT ACTIVITY	
Missouri	NO CURRENT ACTIVITY	
Montana		MONT. CODE ANN. § 33-35-306 (1995/2013).

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<b>NAIC MEMBER</b>	<b>MODEL ADOPTION</b>	<b>RELATED STATE ACTIVITY</b>
Nebraska		210 NEB. ADMIN. CODE §§ 78.001 to 78.015 (2008).
Nevada	NO CURRENT ACTIVITY	
New Hampshire	NO CURRENT ACTIVITY	
New Jersey	NO CURRENT ACTIVITY	
New Mexico		N.M. CODE R. §§ 13.19.3.1 to 13.19.3.15 (1992/1997).
New York		Circular Letter 8 (1991).
North Carolina		11 N.C. ADMIN. CODE 18.0118 (2008).
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 1739.01 to 1739.27 (2004/2014) (May not represent unlicensed MEWA).
Oklahoma	NO CURRENT ACTIVITY	
Oregon	NO CURRENT ACTIVITY	
Pennsylvania		Insurance Dept. Notice 1992-2 (1992) (Joint state/federal statement).
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		02-031-13 R.I. CODE R. §§ 1 to 6 (2009).
South Carolina		S.C. CODE ANN. §§ 38-41- 10 to 38-41-25 (1993/2013); BULLETIN 77-10 (1977).

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<b>NAIC MEMBER</b>	<b>MODEL ADOPTION</b>	<b>RELATED STATE ACTIVITY</b>
South Dakota	NO CURRENT ACTIVITY	
Tennessee		BULLETIN dated May 7, 1992.
Texas		Letter to Texas agents dated September 20, 1991. (Joint state/federal statement).
Utah		UTAH ADMIN. CODE r. 590-88 (1989).
Vermont	NO CURRENT ACTIVITY	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	NO CURRENT ACTIVITY	
Washington	NO CURRENT ACTIVITY	
West Virginia	NO CURRENT ACTIVITY	
Wisconsin		WIS. ADMIN. CODE INS. § 6.62 (1990).
Wyoming	NO CURRENT ACTIVITY	

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For many years regulators recognized problems with the regulation of multiple employer welfare arrangements (MEWAs). In 1990 a task force began development of a workbook to assist regulators. One of the suggestions made concerned “declare yourself” statutes and other jurisdictional issues. **1990 Proc. II 683.**

As work progressed on the handbook, the drafting group became convinced of the need for more uniform treatment of MEWAs and for a model law requiring plans to report to the state insurance departments. **1991 Proc. IB 808.**

At the end of 1990 the working group requested a charge to develop a model act to require reporting to the states by multiple employer welfare arrangements. **1991 Proc. IB 795.**

### **Section 1. Statement of Purpose**

By early 1991 a subgroup had been appointed to develop a model regulation to require agents and other licensees who provide service or coverage to multiple employer welfare arrangements to make filings with the commissioner. **1991 Proc. IIB 965.**

The chair of the working group pointed out that this was not a licensing regulation, but rather a requirement for an informational filing for disclosure from certain licensees before dealing with certain types of entities. **1992 Proc. IB 1119.**

### **Section 2. Definitions**

The definitions of “fully insured by a licensed insurer,” “employee leasing arrangement,” “collectively bargained arrangement” and “reportable MEWA” were carefully crafted to identify particular entities which, in certain circumstances specified later in the model regulation, had been a cause for regulatory concern. **1992 Proc. IB 1119.**

### **Section 3. Agents and Brokers Prohibited From Assisting Reportable MEWAs Prior to Filing**

The provision requires producers to make an informational filing prior to soliciting business or performing other services on behalf of specified self-funded multiple employer arrangements subject to state law under the federal Employee Retirement Income Security Act (ERISA). **1992 Proc. IB 1119.**

### **Section 4. Agents and Brokers Prohibited From Assisting Employee Leasing Arrangements Prior to Filing**

This provision requires producers to make an informational filing prior to soliciting business for an employee leasing firm. The sale of employee leasing services by an agent was a sufficient cause for regulatory concern. The chair of the working group discussed problems in several states where producers sold unauthorized coverage in now insolvent firms through the questionable employee leasing arrangements. **1992 Proc. IB 1119.**

Before final adoption of the draft, one attendee at the working group session suggested a reference be included in the model regulation to ensure that regulators are aware of the recently adopted NAIC model that requires a filing by employee leasing firms for workers’ compensation purposes. The working group voted to insert a drafting note reference to the NAIC model on employee leasing. **1992 Proc. IIB 720.**

### **Section 5. Agents and Brokers Prohibited From Assisting Collectively Bargained Arrangements Prior to Filing**

The requirements of this section are similar to those of the previous section. The chair of the working group explained that the sale by a producer of coverage under a collective bargaining arrangement was a sufficient cause for regulatory concern. He reported problems in several states with producers selling coverage offered by questionable collective bargaining arrangements. He emphasized that this provision was in no way intended to affect legitimate collective bargaining. **1992 Proc. IB 1119.**

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#### **Section 6. Third-Party Administrators and Licensed Insurers Prohibited From Assisting Reportable MEWAs Prior to Filing**

This section contains a requirement for an informational filing for licensees providing administrative services such as claims processing, for certain unauthorized self-funded entities. **1992 Proc. IB 1120.**

#### **Section 7. Lack of Knowledge Not a Defense**

This is a strict liability provision. Neither lack of knowledge or intent is a defense. Licensees will not be able to rely on statements from a self-funded entity that it has filed all of the necessary information. **1992 Proc. IB 1120.**

#### **Section 8. Information Required to be Filed and Kept Current**

In the exposure draft, agents, brokers, third-party administrators and insurers were required to file the following information: (1) Copy of organizational documents; (2) Copy of pertinent insurance or reinsurance contracts; (3) Statement of extent of insurance or reinsurance of benefits; (4) Names and addresses of third-party administrators; and (5) Most recent financial statement. **1992 Proc. IB 1120.**

Before final adoption the requirement for a financial statement was deleted. **1992 Proc. IIB 723.**

While reviewing the exposure draft, one person asked if multiple filings were anticipated. The chair responded that multiple filings were sought—filings by each agent and each licensee. **1992 Proc. IB 1120.**

In response to comments on the exposure draft, the working group prepared revisions to the model draft. One industry association representative stated that she was pleased to see that changes had been made to make the filing requirements more reasonable and she supported the revisions. **1992 Proc. IIB 720.**

#### **Section 9. Liability for Violation of This Rule**

The working group chair explained that, under the Unfair Trade Practices Model Act, licensees who transact unauthorized business are liable for unpaid claims. **1992 Proc. IB 1120.**

An association representative who advocated to the working group that this section be amended to require a finding of a violation be made by the commissioner prior to any penalty being applicable under the regulation. Her concern was potential liability in a private action brought under the model regulation. **1992 Proc. IIB 720.**

A regulator countered by pointing out that the NAIC Unauthorized Insurer Model Act, which was the statutory basis for the draft model regulation, established liability for a violation without any finding by the commissioner. He stated that the purpose of the draft model regulation was to define and clarify the Act, and that a statutory amendment might be needed to require a finding prior to liability. Another regulator stated that this draft regulation was intended to address the problem of licensees selling unauthorized coverage to consumers who often face large losses from unpaid claims. He thought it would be inappropriate to erect a barrier to recovery for these deserving victims. Another regulator pointed out that the filing requirements in the model regulation were intended to protect licensees by requiring them to seek clarification of an entity's status prior to assisting in the offering of coverage on its behalf. **1992 Proc. IIB 720.**

The association representative who advocated the finding suggested that the working group could clarify the statute by providing for a finding, but conceded that the change of being drawn unfairly into private litigation had been greatly reduced due to the revisions to the model draft. **1992 Proc. IIB 720.**



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**Section 9** (cont.)

Another association representative stated that his organization was in general agreement with the purpose of the draft regulation, but suggested that Section 9 be amended to reduce or eliminate liability for a licensee who failed to make a required filing in the instance that the injured party was otherwise reimbursed for the loss. **1992 Proc. IIB 720.**

The chair responded that the NAIC Unauthorized Insurers Model Act provided that an individual that aids in the procurement of unauthorized insurance is liable for any unpaid claims as provided in the contract. Any coordination of benefit or subrogation provisions in the contract would be available as defenses for a violator of the Act or draft model regulation. The chair also pointed out that the suggested change would provide a consumer with unauthorized coverage with fewer legal protections than if the contract had been properly insured. **1992 Proc. IIB 720.**

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*Chronological Summary of Actions*

*June 1992: Model adopted.*

*June 2007: Adopted Guideline amendments.*

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