Chapter 21

Fraternals and Small Mutuals

Fraternal Benefit Societies

A fraternal benefit society is a membership organization that is legally required to offer life, health and related insurance products to its members, be not-for-profit, and carry out charitable and other programs for the benefit of its members and the public. It must be composed of members having a common bond and be organized into lodges or chapters (local membership groups). A fraternal benefit society exists solely for the benefit of its members and their beneficiaries. Fraternal benefit societies must have a representative form of governance.

Federal law allows a fraternal to offer life and health insurance products. Section 501(c)(8) of the IRC defines a fraternal beneficiary society as:

(a) a nonprofit mutual aid organization;
(b) operating under the lodge system or for the exclusive benefit of the members of a fraternity itself operating under the lodge system; and
(c) providing for the payment of life, sick, accident or other benefits to the members of such society, order or association, or their dependents.

Fraternal benefit societies offer insurance products, are chartered and licensed according to state insurance laws, and are regulated and examined by state insurance departments. Individuals who sell, solicit or negotiate insurance products for a fraternal benefit society are required to obtain a state insurance producer license.

The NAIC has adopted the *Uniform Fraternal Code* (*#675*). However, this model is not widely in use. At this writing, 45 states had adopted a version of the *Model Fraternal Code* as drafted by the National Fraternal Congress of America (NFCA). Both the NAIC model and the NFCA model contain a section about producer licensing that pre-dates the PLMA. States should check the fraternal law that has been adopted in their state and update it to reference the PLMA.

Small Mutual Insurers

Small mutual insurers are risk-bearing entities that historically formed around common interests of farmers, householders, and ethnic and religious groups. Small mutuals, commonly known as farm mutuals, may also be called “town” or “county” or “state” mutuals.

Small mutuals provide, with only a few exceptions, property insurance for homes, farmsteads, crops and some small businesses. They do not, except for the legal liability associated with those risks, write casualty insurance. In some states, small mutuals are allowed to offer liability coverage through an affiliation with an insurer. State laws usually limit small mutuals to either a certain premium volume or geographic area or both. Most states also impose a lighter regulatory burden than that applied to larger mutual and investor-owned insurers.

Mutual insurers are owned and operated by the policyholders. Unlike a stock company, a mutual policyholder has an indivisible interest in the enterprise that, in general, cannot be bought or sold like a share of stock. Policyholders often are referred to as “members.” In some cases, a dividend or return of premium is paid when the mutual’s board of directors judges it has sufficient capital. Members of the board also are policyholders.

Individuals who sell products for small mutuals should be licensed as producers as outlined in the PLMA and the ULS.

Chapter 22

Insurance Consultants

An insurance consultant is a person who charges a fee for giving advice about insurance products. Not all states require a separate consultant license. In those states, the individual can obtain a producer license and abide by the disclosure provisions for insurance consultants. In states that do require a special license, the applicant usually is required to pass an examination. The exam may be either one of the same subject-matter examinations that insurance producers must pass or an examination specific to consultants. In states that require an examination, a waiver may be granted if the applicant can demonstrate a specified amount of insurance experience.

States usually adopt exemptions from the consultant licensing requirement. The exemptions are available as long as the person is acting in his or her professional capacity or in the normal course of business. Common exemptions are:

1. A licensed attorney.
2. A trust officer of a bank.
3. An actuary or certified public accountant.
4. A risk manager who consults for his or her employer only.

If a state requires appointments for insurance producers, appointments should not be required of insurance consultants. The consultant represents the insured and is not an agent of the insurance company. Some states prohibit an individual from holding both an insurance producer license and an insurance consultant license. Other states allow an insurance producer to function in either capacity with full disclosure. In all cases where an individual is acting as an insurance consultant, a written contract should be used to clearly explain the terms of the consultant arrangement.

In states that have a separate insurance consultant license, it is a common practice to have a CE requirement that mirrors the CE requirement for insurance producers.

Chapter 23

Managed Care Providers

Health Maintenance Organizations

A health maintenance organization (HMO) is a type of managed care organization that provides a form of health care coverage that is fulfilled through hospitals, doctors and other providers with which the HMO has a contract. Unlike traditional health insurance, an HMO sets out guidelines under which doctors can operate. On average, an HMO costs less than comparable traditional health insurance, with a trade-off of limitations on the range of treatments available. Unlike many traditional insurers, HMOs do not merely provide financing for medical care. The HMO actually delivers the treatment as well. Doctors, hospitals and insurers all participate in the HMO business arrangement.

The NAIC has adopted a model law and regulation that governs the licensure of HMOs: Health Maintenance Organization Model Act *(#430*) and Model Regulation to Implement Rules Regarding Contracts and Services of Health Maintenance Organization *(#432*). In most cases, access to an HMO is only available to employer group plans.

Preferred Provider Organizations

A preferred provider organization (PPO) is a group of doctors and/or hospitals that provides medical service only to a specific group or association. The PPO may be sponsored by a particular insurance company, by one or more employers, or by some other type of organization. PPO physicians provide medical services to the policyholders, employees or members of the sponsor(s) at discounted rates and may set up utilization review programs to help control the cost of medical care.

In some states, managed care providers may be licensed by an agency outside the insurance department.

Chapter 24

Managing General Agents

A managing general agent (MGA) is an insurance producer authorized by an insurance company to manage all or part of the insurer's business in a specific geographic territory. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. Many states regulate the activities and contracts of MGAs.

The NAIC has adopted the *Managing General Agents Act* (*Model #225*) to guide states in regulating MGAs. Under the model, an MGA is defined as any person who engages in all of the following:

1. Negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer—including the management of a separate division, department or underwriting office—and who acts as an agent for such insurer whether known as a managing general agent, manager or other similar term or title.
2. With or without authority and either separately or together with affiliates, directly or indirectly produces and underwrites an amount of gross direct written premium equal to or greater than 5% of the policyholder surplus in any one quarter or year, as reported in the last annual statement of the insurer.
3. Engages in either or both of the following:

   (a) Adjusts or pays claims in excess of an amount determined by the insurance commissioner.
   (b) Negotiates reinsurance on behalf of the insurer.

Under the model, an MGA does not include any of the following:

1. An employee of the insurer.
2. A manager of a U.S. branch of an alien insurer who resides in this country.
3. An underwriting manager who, pursuant to contract, manages all insurance operations of the insurer, who is under common control with the insurer, subject to [cite to state law] relating to the regulation of insurance holding company systems, and who is not compensated based upon the volume of premiums written.
4. An insurance company, in connection with the acceptance or rejection of reinsurance on a block of business.
5. The attorney-in-fact authorized by or acting for the subscribers of a reciprocal insurer or interinsurance exchange under a power of attorney.

In most states, MGAs must be licensed as producers and are not allowed to place business until a written contract exists among all parties. Under the *Model #225*, insurers are required to monitor the financial stability of MGAs under contract.

Chapter 25

Multiple Employer Welfare Arrangements

Multiple employer welfare arrangements (MEWAs) are arrangements that allow a group of employers collectively to offer health insurance coverage to their employees. MEWAs are most often found among employer groups belonging to a common trade, industry or professional association.

MEWA plans are generally available to the employees (and sometimes their dependents) of the employers who are part of the arrangement. People who do not have an employment connection to the group cannot obtain coverage through the MEWA plan. MEWA plans cannot be sold to the public.

To qualify as an MEWA, the organization must be nonprofit, in existence for at least five years and created for purposes other than that of obtaining health insurance coverage. In other words, employers cannot group together solely for the purpose of offering health insurance. However, employers that already have grouped together for another common purpose (for example, a trade association) may also offer health insurance coverage to their member employers.

States and the federal government coordinate the regulation of MEWAs pursuant to a 1982 amendment to the federal Employee Retirement Income Security Act (ERISA). This dual jurisdiction gives states primary responsibility for overseeing the financial soundness of MEWAs and the licensing of MEWA operators. The U.S. Department of Labor (DOL) enforces the fiduciary provisions of ERISA against MEWA operators to the extent a MEWA is an ERISA plan or is holding plan assets. State insurance laws that set standards requiring specified levels of reserves or contributions are applicable to MEWAs even if they also are covered by ERISA.

The NAIC has adopted a model regulation, *Prevention of Illegal Multiple Employer Welfare Arrangements* (MEWAs) and *Other Illegal Health Insurers Model Regulation* (*#220*), to give guidance to states in the supervision of MEWAs.