



Testimony

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Senate

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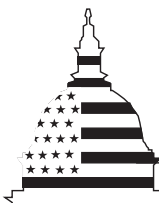
PRIVATE HEALTH INSURANCE

Unauthorized or Bogus Entities Have Exploited Employers and Individuals Seeking Affordable Coverage

Statement of

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Highlights of [GAO-04-512T](#), a testimony before the Committee on Finance, U.S. Senate

Why GAO Did This Study

As health insurance premiums have risen at double-digit rates in recent years, employers and individuals who have sought to purchase more affordable coverage have fallen prey to certain entities that may offer attractively priced premiums but do not fulfill the expectations of those buying health insurance. These unauthorized entities—also known as bogus entities or scams—may not meet the financial and benefit requirements typically associated with health insurance products or other arrangements that are authorized, licensed, and regulated by the states.

This testimony is based on GAO's recent report *Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, [GAO-04-312](#) (Feb. 27, 2004). In this testimony, GAO was asked to identify the number of entities that operated from 2000 through 2002 and the number of employers and policyholders affected, approaches and characteristics of these entities' operations, and the actions federal and state governments took against these entities. GAO analyzed information obtained from the Department of Labor (DOL) and from a survey of insurance departments in the states; interviewed officials at DOL and at insurance departments in Colorado, Florida, Georgia, and Texas; and examined the operations of one of the largest entities—Employers Mutual, LLC.

www.gao.gov/cgi-bin/getrpt?GAO-04-512T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or Robert J. Cramer at (202) 512-7455.

PRIVATE HEALTH INSURANCE

Unauthorized or Bogus Entities Have Exploited Employers and Individuals Seeking Affordable Coverage

What GAO Found

DOL and the states identified 144 unique entities not authorized to sell health benefits coverage from 2000 through 2002. Although every state was affected by at least 5 of these entities, these entities were most often identified in southern states. These unauthorized entities covered at least 15,000 employers and more than 200,000 policyholders. The entities also left at least \$252 million in unpaid medical claims, only about 21 percent of which had been recovered at the time of GAO's 2003 survey.

In most cases, the operators characterized their entities as one of several types to give the appearance of being exempt from state regulation, but states found that they actually were subject to state regulation. Other characteristics that were common among at least some of these entities included

- adopting names that were familiar to consumers or similar to legitimate firms,
- marketing their products through licensed agents and with other health care or administrative service companies,
- setting premiums below market rates,
- marketing to employers or individuals that were particularly likely to be seeking affordable insurance alternatives, and
- paying initial claims while collecting additional premiums before ceasing claims payments.

Employers Mutual adopted many of these characteristics as it collected approximately \$16 million in premiums from over 22,000 people in 2001, leaving more than \$24 million in medical claims unpaid.

Both federal and state governments—individually and collaboratively—took action against these entities and sought to increase public awareness. For example, state insurance departments issued cease and desist orders against 41 of the 144 entities, and DOL obtained court orders against three large entities from 2000 through 2002. States also took other actions against some entities' operators and agents that received commissions for marketing these entities. Further state or federal actions remain possible as many investigations remain ongoing. States and DOL primarily focused their prevention efforts on improving public awareness, including the need for consumers, employers, and insurance agents to verify an entity's legitimacy with insurance departments.

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you address how employers and individuals have been exploited by unauthorized or bogus entities selling health benefits. As private health insurance premiums have risen at double-digit rates in recent years, employers and individuals who have sought to purchase more affordable coverage have fallen prey to certain entities that may offer attractively priced premiums but do not fulfill the expectations of those buying health insurance coverage. These unauthorized entities—also sometimes referred to as bogus entities or scams—may price their products below market rates to attract purchasers but may not meet the financial and benefit requirements typically associated with health insurance products or other arrangements that are authorized, licensed, and regulated by the states. When these entities do not pay legitimate claims for the costs of care that policyholders incur, the harm can affect several parties: individuals may be held responsible for their own medical bills, which can mean owing thousands of dollars; employers may find that they have paid premiums for nonexistent coverage for their employees; and health care providers may be at increased risk of not being paid for services already rendered. In addition, federal and state governments may need to invest significant public resources to investigate and shut down these unauthorized entities.

Our testimony will summarize findings of a report that we are releasing today that examines the prevalence of these entities and their impact on employers, especially small employers, and policyholders.¹ At your request, Mr. Chairman, together with Senator Snowe, Chair of the Senate Committee on Small Business and Entrepreneurship, and Senator Bond, we examined (1) the number of unauthorized entities selling health benefits that federal and state governments identified from 2000 through 2002, the number of employers and policyholders affected, and the amount of unpaid claims involved, (2) approaches and characteristics of these entities' operations, and (3) the methods federal and state governments have employed to identify such entities and to stop or prevent them from continuing to operate. We surveyed each state's insurance department in

¹U.S. General Accounting Office, *Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage*, [GAO-04-312](#) (Washington, D.C.: Feb. 27, 2004). We conducted our work for the report from January 2003 through February 2004 in accordance with generally accepted government auditing standards.

2003, including that of the District of Columbia,² and also obtained data from the Department of Labor's (DOL) Employee Benefits Security Administration (EBSA), which conducts civil and criminal investigations of employer-based health plans.³ We consolidated information from DOL and the states to determine the unduplicated number of entities identified from 2000 through 2002 and the numbers of affected employers and policyholders.⁴ We also asked states to provide information on a related type of problematic arrangement—discount arrangements that may be misrepresented as insurance. We interviewed officials with EBSA, including those in three of its regional offices (Atlanta, Dallas, and San Francisco); the National Association of Insurance Commissioners (NAIC); insurance departments in four states that were identified as being affected by a relatively large number of these entities (Colorado, Florida, Georgia, and Texas); and other experts and associations, including those representing insurance agents and administrators of employers' health benefits. Because many of the federal and state investigations regarding these entities were ongoing at the time we did our work, we generally do not name specific entities except in situations in which publicly disclosed actions have been taken against an entity. We also examined in detail the operations of one of the largest entities identified during this period, Employers Mutual, LLC, and the actions federal and state governments took to stop it from operating.

In summary, DOL and the states identified 144 unique entities not authorized to sell health benefits coverage from 2000 through 2002. Although every state was affected, with at least five entities marketed in each state, these entities were most often identified in southern states. Specifically, of the seven states with at least 25 entities, five were located in the South. These 144 unauthorized entities covered at least 15,000 employers and more than 200,000 policyholders from 2000 through 2002. At the time of our 2003 survey, DOL and the states reported that the

²Throughout this testimony, we include the District of Columbia in our discussion of states; we refer to each state's insurance department, division, or office as an insurance department.

³In conducting our state survey, we asked states to use the following definition: "an unauthorized health benefits plan is defined as an entity that sold health benefits, collected premiums, and did not pay or was likely not to pay some or all covered claims. These entities are also known as insurance scams." We asked EBSA to provide information using a similar definition.

⁴States provided data on the number of policyholders and DOL provided data on the number of participants; we refer to the combined data as policyholders in this testimony.

identified entities did not pay at least \$252 million in medical claims and only about \$52 million—about 21 percent of the total unpaid claims—had been recovered on behalf of policyholders and those covered by the policies.

Most unauthorized entities characterized themselves as one of several types of arrangements and some had other approaches in common. For example, the operators of these entities often characterized the entities in one of several ways that gave an appearance of being exempt from state insurance regulation when they should have been subject to regulation. Some entities selected names that resembled legitimate insurers or employee benefit firms and recruited insurance agents, administrative services companies, and health care provider networks to enhance their appearance of legitimacy to consumers and employers. The entities typically set their prices below market rates to be attractive especially to employers or individuals seeking more affordable health insurance alternatives. One of the largest entities, Employers Mutual, used a name similar to the long-established, Iowa-based Employers Mutual Casualty Company; established associations to sell its products; marketed its products through licensed insurance agents and contracted with other companies for administrative services; and, according to court documents, set premiums by underpricing the average of sample rates posted on the Internet. According to court documents and DOL, during a 10-month period in 2001, Employers Mutual collected approximately \$16 million in premiums from over 22,000 people and did not pay more than \$24 million in medical claims for which they were liable.

Both federal and state governments—individually and collaboratively—took action against these entities and sought to increase public awareness. For example, state insurance departments issued cease and desist orders against 41 of the 144 unique entities identified from 2000 through 2002. Such an order, however, only applies to the activity in the issuing state. States reported also taking other actions, such as filing cases against the entities' operators in civil or criminal courts or fining agents or revoking their licenses for selling unauthorized coverage. DOL obtained court orders against three large entities from 2000 through 2002 that prevented their operations nationwide. Further actions remain possible as many investigations remain ongoing. States and DOL primarily focused their prevention efforts on improving public awareness, including the need for consumers, employers, and insurance agents to verify an entity's legitimacy with insurance departments.

Background

States regulate the insurance products that many employers and individuals purchase. Each state's insurance department enforces the state's insurance statutes and rules. Among the functions state insurance departments typically perform are licensing insurance companies, managed care plans, and the agents who sell their products; regulating insurers' financial operations to ensure that funds are adequate to pay policyholders' claims; reviewing premium rates; reviewing and approving policies and marketing materials to ensure that they are not vague and misleading; and implementing various consumer protections, such as assisting people who do not receive health benefits that are covered through insurance products or by providing an appeals process for denied claims.⁵

The federal government regulates most private employer-sponsored pension and welfare benefit plans (including health benefit plans) as required by the Employee Retirement Income Security Act of 1974 (ERISA).⁶ These plans include those provided by an employer, an employee organization (such as a union), or multiple employers through a multiple employer welfare arrangement (MEWA).⁷ DOL is primarily responsible for administering Title I of ERISA. Among other requirements, ERISA establishes plan reporting and disclosure requirements and sets fiduciary standards for the persons who manage and administer the plans.⁸ These requirements generally apply to all ERISA-covered employer-sponsored health plans, but certain requirements vary depending on the size of the employer or whether the coverage provided is through an insurance policy or a self-funded plan where the employer assumes the risk associated with paying directly for at least some of their employees' health care costs. In addition, ERISA generally preempts states from directly regulating employer-sponsored health plans (although maintaining

⁵State insurance regulators established NAIC to help promote effective insurance regulation, to encourage uniformity in approaches to regulation, and to help coordinate states' activities. Among other things, NAIC develops model laws and regulations to assist states in formulating their policies to regulate insurance.

⁶Pub. L. No. 93-406, 88 Stat. 829.

⁷MEWAs are plans or other arrangements that provide health and welfare benefits to the employees of two or more employers. Under ERISA, MEWAs do not include certain plans that the Secretary of Labor finds are collective bargaining agreements, or plans established or maintained by a rural electric cooperative or a rural telephone cooperative association.

⁸Under ERISA, a fiduciary generally is any person who exercises discretionary authority or control respecting the management or administration of an employee benefit plan or the management or disposition of the plan's assets.

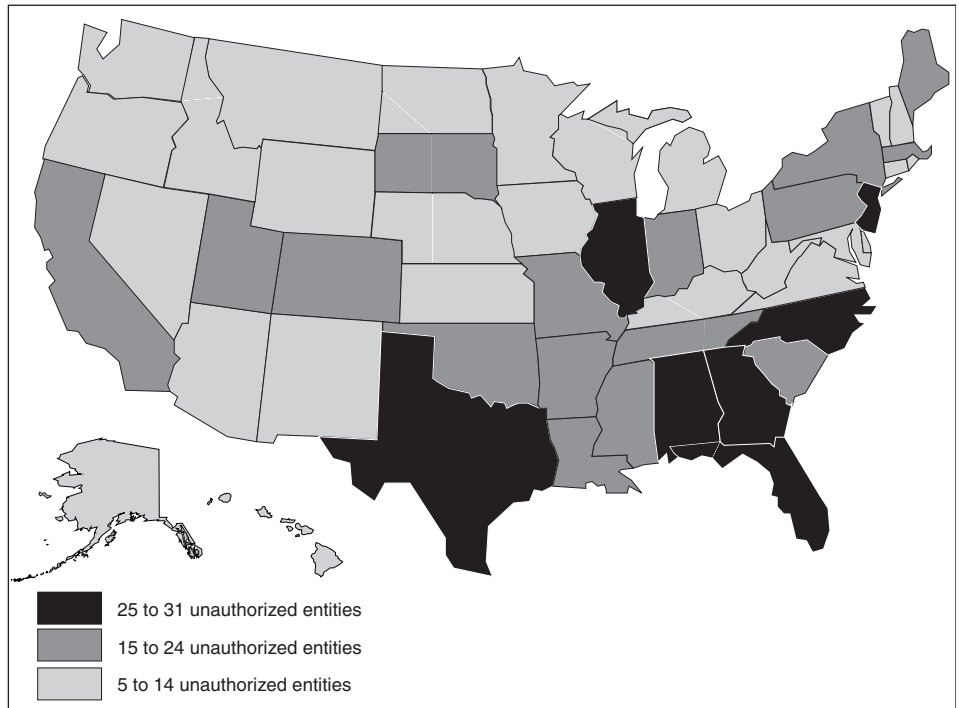
states' authority to regulate insurers and insurance policies). Therefore, under ERISA, self-funded employer group health plans generally are not subject to the state oversight that applies to insurance companies and health insurance policies. The federal and state governments coordinate their regulation of MEWAs, with states having the primary responsibility to regulate the fiscal soundness of MEWAs and to license their operators, and DOL enforcing ERISA's requirements.

DOL and States Identified 144 Unique Unauthorized Entities Operating from 2000 through 2002 That Left More Than \$250 Million in Unpaid Claims

DOL and the states identified 144 unauthorized entities from 2000 through 2002. This likely represents the minimum number of unauthorized entities operating during this period because some states did not report on entities that they were still investigating. The number of unauthorized entities newly identified by DOL and the states each year almost doubled from 2000, when 31 were newly identified, through 2002, when 60 were newly identified.

DOL and the states found that every state had at least 5 entities operating in it. Specifically, the number of entities per state ranged from 5 in Delaware and Vermont to 31 in Texas. (See fig. 1.) Many entities marketed their products in more than one state, and some operated under more than one name or with more than one affiliated entity. These entities were concentrated in certain states and regions. Seven states had 25 or more entities that operated during this period; 5 of these states were located in the South. In addition to the 31 entities in Texas, 30 were in Florida, 29 each in Illinois and North Carolina, 28 in New Jersey, 27 in Alabama, and 25 in Georgia.

Figure 1: Number of Unauthorized Entities That Operated in Each State, 2000-2002



Source: GAO analysis of DOL and state data.

Note: Some of the unauthorized entities operated in more than one state so the total number of entities identified by DOL and the states exceeds the total of 144 unique entities.

At least 15,000 employers purchased coverage from unauthorized entities, affecting more than 200,000 policyholders from 2000 through 2002. The number of individuals covered by unauthorized entities was even greater than the more than 200,000 policyholders covered because the policyholder could be an employer that purchased coverage on behalf of its employees or the policyholder could be an individual with dependents. Therefore, any one policyholder could represent more than one individual. The states reported that more than half of the entities they identified frequently targeted their health benefits to small employers.

At the time of our 2003 survey, DOL and states reported that the 144 entities had not paid at least \$252 million in medical claims. This represents the minimum amount of unpaid claims associated with these entities identified from 2000 through 2002 because in some cases DOL and the states did not have complete information on unpaid claims for the entities they reported to us. Federal and state governments reported that

about 21 percent of unpaid claims had been recovered from entities identified from 2000 through 2002—\$52 million of \$252 million. These recoveries could include assets seized from unauthorized entities that have been shut down or frozen from other uses. Licensed insurance agents who have marketed products offered by these entities have also reimbursed unpaid claims either voluntarily or through state or court action.⁹ Additional assets may be recovered from the entities identified from 2000 through 2002 because investigations and federal and state actions remain ongoing.¹⁰ However, it is likely that many of the assets will remain unrecovered because federal and state investigators report that the entities often are nearing bankruptcy when detected or otherwise have few remaining assets with which to pay claims.

A few entities were responsible for a large share of the affected employers and policyholders and the resulting unpaid claims. Of the 144 unique entities, 10 alone covered about 64 percent of the employers and about 56 percent of the policyholders. They also accounted for 46 percent of the unpaid claims.

In addition to the unauthorized entities selling health benefits, 14 states reported that discount plans were inappropriately marketed as health insurance products in some manner. Unlike legitimate insurance, discount plans do not assume any financial risk nor do they pay any health care claims. Instead, for a fee they provide a list of health care providers that have agreed to provide their services at a discounted rate to participants. In response to our survey, 40 states reported that they were aware that discount plans were marketed in their state. While discount plans are not problematic as long as purchasers clearly understand them, 14 of these states reported that some discount plans were misrepresented as health insurance. For example, some discount plans were marketed with terms or phrases such as “medical plan,” “health benefits,” or “pre-existing conditions immediately accepted.” However, state insurance departments do not regulate discount plans because they are not considered to be health insurance. Thus, while state insurance departments might be aware that discount plans operated within their borders, they would not necessarily be able to quantify the extent to which they exist.

⁹The four states whose officials we interviewed had laws imposing penalties on agents and others who represented such products.

¹⁰Most states and DOL reported to us from March through June 2003.

Most Unauthorized Entities Characterized Themselves as One of Several Types of Arrangements and Some Had Other Approaches in Common

The 144 entities that federal and state governments identified from 2000 through 2002 varied in size and specific characteristics, but most were variations of one of four types of arrangements and some had other approaches in common that enhanced their appearance of legitimacy and attractiveness to prospective purchasers. For example, about 80 percent of the entities characterized themselves as one of four arrangements—associations, professional employer organizations, unions, or single-employer ERISA plans—or some combination of these arrangements. According to DOL and the states, specifically:

- 27 percent of the entities characterized themselves as association arrangements through which employers or individuals bought health benefits through existing legitimate associations or through newly created associations established by the unauthorized entities. Although some of these entities claimed that this structure would shield them from oversight by federal or state governments, these associations would be subject to federal and state oversight if they were determined to be MEWAs.
- 26 percent of the entities were identified as professional employer organizations, also known as employee leasing firms, which contracted with employers to administer employee benefits and perform other administrative services for contract employees. However, professional employee organizations could be subject to federal and state requirements if, in addition to providing administrative services, they managed assets or controlled benefits for multiple employers.
- 9 percent of the entities identified claimed to be union arrangements that would be exempt from state regulation. However, they lacked legitimate collective bargaining agreements and were therefore subject to state oversight.
- 8 percent of the entities identified characterized themselves as single-employer ERISA plans and claimed to be administering a self-funded plan for a single employer. Such plans, when administered with funds from one employer for the benefit of one employer's workers, are exempt from state insurance regulation under ERISA. However, assets for several employers were commingled in these entities, making them MEWAs subject to state regulation.
- 10 percent of the entities were reported as a combination of one of these or other types of arrangements.

The operators of these entities often characterized the entities as one of these common types to give the appearance of being exempt from state regulation, but often states found that they actually were subject to state regulation as insurance arrangements or MEWAs.

These entities sometimes took other steps to enhance their appearance of legitimacy and make their products attractive to prospective purchasers. For example, some entities

- adopted names that were familiar to consumers or similar to those of legitimate firms;
- marketed their products through licensed agents;
- established relationships with networks of health care providers and with companies that provide administrative services for employers offering health benefits;
- set premiums below market rates;
- marketed to employers or individuals that were particularly likely to be seeking affordable insurance alternatives, such as small employers, workers in industries such as construction or transportation who are disproportionately more likely to be uninsured, and self-employed individuals; and
- paid initial claims while collecting additional premiums before ceasing claims payments.

One of the most widespread entities during the period we examined that illustrates some of these approaches was Employers Mutual, incorporated in Nevada in July 2000. According to court documents and DOL, four individuals (“the principals”) operated Employers Mutual and, during a 10-month period from January through October 2001, collected a total of approximately \$16 million in premiums in every state from over 22,000 people. Today, more than \$24 million in medical claims against Employers Mutual remain unpaid.

The name Employers Mutual is similar to the name of a long-established Iowa-based insurance company marketed throughout the United States, Employers Mutual Casualty Company, which had no affiliation with Employers Mutual. Notably, both in 1998 and in 2000, one of the Employers Mutual principals was found to have engaged in the health care

insurance business in California without a license and was barred from engaging in any insurance business in that state.

Two of the principals formed 16 associations having names relating to workers in a wide array of industries and professions, such as farmers, construction workers, mechanics, and food service employees. Principals were named as the “managing members” of all 16 associations and created an employee health benefit plan for each association. The principals contracted with legitimate firms to process claims and to market the plans to employers nationwide. Employers Mutual claimed that it was exempt from DOL regulation.

One of the principals, who was not a licensed actuary and had no formal training, set the premiums for the 16 plans after he calculated the average of sample rates posted by insurance companies on the Internet and reduced them to ensure that Employers Mutual offered low prices. The principals also formed two companies, Columbia Health Network and Western Health Network, that purported to provide networks of health care providers for people insured by Employers Mutual. Additionally, the principals formed two other companies, Graf Investments and WRK Investments, which purported to provide investment services. However, these companies were found to be vehicles for the illegal diversion of over \$1.3 million of plan assets.¹¹

When Nevada insurance regulators became aware of Employers Mutual, they found that it was transacting insurance business without a certificate of authority as required by Nevada law¹² and issued a cease and desist order against Employers Mutual in June 2001.¹³ Subsequently, other states also issued cease and desist orders against Employers Mutual. In December 2001, based on a petition from DOL, the U.S. District Court for the District of Nevada granted a temporary restraining order against Employers Mutual and its four principals.¹⁴ The restraining order temporarily froze the assets of all the principals and prohibited them from

¹¹*Chao v. Graf*, No. 01-0698, (D. Nev. Sep. 10, 2003) (order granting permanent injunction).

¹²Nev. Rev. Stat. §§ 685B.030, 685B.035 (2003).

¹³Cease and Desist Order: Employers Mutual, L.L.C., Nevada Department of Business and Industry Division of Insurance case no. 01.658 (June 14, 2001).

¹⁴*Chao v. Graf*, No. 01-0698, (D. Nev. Dec. 13, 2001) (order granting temporary restraining order).

conducting further activities related to the business. It also appointed an independent fiduciary to administer Employers Mutual and associated entities and, if necessary, implement their orderly termination. On September 10, 2003, the district court issued a default judgment granting a permanent injunction against the principals and ordered them to pay \$7.3 million in losses suffered as a result of their breach of fiduciary obligations to beneficiaries.¹⁵ The fiduciary has also sued and sought settlements from insurance agents who marketed or sold Employers Mutual's plan for damages and relief from unpaid or unreimbursed claims. Employers Mutual is also under investigation by law enforcement authorities. Appendix I includes a chronology of events from Employers Mutual's establishment to state and federal actions to shut it down.

States and DOL Share Responsibility for Identifying, Stopping, and Preventing the Establishment of Unauthorized Entities

Both federal and state governments have responsibility for identifying unauthorized entities and stopping and preventing them from exploiting businesses and individuals. DOL's EBSA conducts civil and criminal investigations of employer-based health benefits plans that are alleged to violate federal law as part of its responsibilities for enforcing ERISA. For example, EBSA may identify entities whose operators have breached their ERISA fiduciary responsibilities, which generally require managing benefit plans and assets in the interest of participants. State insurance departments investigate entities and individuals that violate state insurance or MEWA requirements, such as selling insurance without a license. Because some entities may violate both federal ERISA requirements and state insurance requirements, both EBSA and states may investigate the same entities or coordinate investigations. Of the 144 unique entities DOL and states identified, the states identified 77 entities that DOL did not, DOL identified 40 that the states did not, and both the states and DOL identified another 27.

States and DOL often relied on the same method to learn of the entities' operations—through consumer complaints. States also received complaints about these entities from several other sources, such as agents, employers, and providers. In addition, NAIC played an important role in the identification process by helping to coordinate and distribute state and federal information on these entities, and states and DOL also reported that they coordinated directly. For example, DOL submitted quarterly reports to NAIC that identified all open civil investigations, the individuals

¹⁵*Chao v. Graf*, No. 01-0698, (D. Nev. Sept. 10, 2003) (order granting permanent injunction).

being investigated, and the EBSA office conducting the investigations. NAIC shared this and other information from EBSA regional offices with state investigators throughout the country.

After identifying the unauthorized entities, the primary mechanism states used to stop them from continuing to operate was the issuance of a cease and desist order. Generally, a state cease and desist order tells the operator of the entity, and affiliated parties, to stop marketing and selling health insurance in that state and in some cases explicitly establishes their continuing responsibility for the payment of claims and other obligations previously incurred. Such an order, however, only applies to the activity in the issuing state. Thirty states reported that they issued a total of 108 cease and desist orders that affected 41 of the 144 unique entities.¹⁶ About 58 percent of policyholders and nearly half of the total unpaid claims were associated with these 41 entities. States also took other actions against some entities, sometimes in conjunction with issuing cease and desist orders. For example, in 48 instances, states responding to our survey reported that they took actions against or sought relief from the agents who sold the entities' products, including fining them, revoking their licenses, or ordering them to pay outstanding claims. States also reported that they took actions against the entity operators in 25 instances and filed cases in court in 14 instances to pursue civil or criminal penalties.

DOL often relied on states to stop unauthorized entities through cease and desist orders while it conducted investigations, usually in multiple states, to obtain the evidence needed to stop these entities' activities nationwide through the federal courts—that is, by seeking injunctive relief and, in some cases, pursuing civil and criminal penalties.¹⁷ DOL's enforcement actions apply to all states. To obtain a temporary restraining order or injunction, DOL must offer sufficient evidence to support its claim that an ERISA violation has occurred and that the government will likely prevail on the merits of the case. As of December 2003, DOL had obtained

¹⁶Twelve states that identified unauthorized entities did not report issuing cease and desist orders regarding the entities they identified, and nine states did not report identifying unauthorized entities.

¹⁷An injunction is an order of a court requiring one to do or refrain from doing specified acts. Injunctive relief sought by DOL against unauthorized entities includes temporary restraining orders, which may be issued without notice to the affected party and are effective for up to 10 days; preliminary injunctions, which may be issued only with notice to the affected party and the opportunity for a hearing; and permanent injunctions, which are granted after a final determination of the facts.

temporary restraining orders against three entities for which investigations were opened from 2000 through 2002. In two of these cases, DOL also obtained preliminary injunctions and in one case ultimately issued a permanent injunction. Each of these actions affected people in at least 41 states. (See table 1.) These three entities combined affected an estimated 25,000 policyholders and accounted for about \$39 million in unpaid claims. Documenting that a fiduciary breach took place can be difficult, time-consuming, and labor-intensive because DOL investigators often must work with poor or nonexistent records, uncooperative parties, and multiple trusts and third-party administrators. As of August 2003, EBSA was continuing to investigate 51 of the 69 entities it had investigated from 2000 through 2002. As a result, further federal actions remain possible.¹⁸

Table 1: Temporary Restraining Orders and Injunctions for Three Unauthorized Entities, as of December 2003

Unauthorized entity	Number of states affected	Temporary restraining order issued ^a	Preliminary injunction obtained	Permanent injunction obtained	Other results
Employers Mutual	51	December 2001	February 2002 ^b	September 2003	In September 2003, a federal court ordered the principals to pay about \$7.3 million.
OTR Truckers Health and Welfare Fund	44	June 2002	None	None	In September 2002, one defendant agreed to pay an amount that was less than 1 percent of the unpaid claims.
Service and Business Workers of America Local 125 Benefit Fund	41	October 2002	October 2002 ^c	None	None

Source: EBSA.

^aGenerally, these temporary restraining orders froze the unauthorized entity's assets; removed the operators; prevented the operators from managing the entity; and appointed an independent fiduciary to manage the entity, account for assets, and pay claims.

^bPreliminary injunction extended appointment of fiduciary and prevented health care providers from taking action against participants to collect unpaid bills.

^cPreliminary injunction ordered termination of the entity and prevented health care providers from taking action against participants to collect unpaid bills or other actions.

¹⁸For example, in addition to the three investigations that had yielded temporary restraining orders or injunctions, EBSA had referred four other case investigations to the DOL Solicitor's Office for potential enforcement action and obtained subpoenas in five cases.

To help prevent unauthorized entities from continuing to operate, the four states we reviewed—Colorado, Florida, Georgia, and Texas—and DOL alerted the public and used other methods. These states, which were among the states with a moderate or high number of entities, and DOL emphasized the need for consumers and employers to check the legitimacy of health insurers before purchasing coverage, thus helping to prevent unauthorized entities from continuing to operate. To help states increase public awareness, NAIC developed a model consumer alert in the fall of 2001, which it distributed to all the states and has available on its Web site. Insurance departments in the four states took various actions to prevent unauthorized entities from continuing to operate. Each of these states issued news releases to alert the public about these entities in general and to publicize the enforcement actions they took against specific entities. The four states' insurance departments also maintained Web sites that allow the public to search for those companies authorized to conduct insurance business within their borders, and some states also released public service announcements via radio, television, or billboards. In addition to increasing public awareness, the four state insurance departments warned insurance agents through bulletins, newsletters, and other methods about these entities, the implications associated with selling their products, and the need to verify the legitimacy of all entities. DOL primarily targeted its prevention efforts to employer groups and small employers. For example, to help increase public awareness about these entities, on August 6, 2002, the Secretary of Labor notified over 70 business leaders and associations, including the U.S. Chamber of Commerce and the National Federation of Independent Business, about insurance tips that the department had developed and asked them to distribute the tips to small employers. Also, the EBSA regional offices initiated various activities within the states in their regions. For example, EBSA's Atlanta regional office sponsored conferences that representatives from 10 states and NAIC attended.

Concluding Observations

Recent double-digit premium increases for health coverage have encouraged employers, particularly small employers, and individuals to search for affordable coverage. At the same time, however, these premium increases have created an environment that makes them vulnerable to being exploited by unauthorized or bogus entities. This has been reflected by the increasing number of these entities identified by federal and state governments in recent years. As a result, tens of thousands of employers and hundreds of thousands of individuals have paid premiums for essentially nonexistent coverage. As many employers and individuals continue to seek affordable health coverage alternatives in this

environment of rising premiums, it is especially important that federal and state governments remain vigilant in identifying, stopping, and preventing the establishment of these entities and continue to caution individuals, employers, and their agents to verify the legitimacy of entities offering coverage.

Mr. Chairman, this completes our prepared statement. We would be happy to respond to any questions you or other Members of the Committee may have at this time.

Contacts and Acknowledgments

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118 or Robert J. Cramer at (202) 512-7455. Other individuals who made key contributions include John Dicken, Joseph Petko, Matthew Puglisi, Andrew O'Connell, and Paul Desaulniers.

Appendix I: Chronology of Key Events Regarding Employers Mutual, LLC

Figure 2 summarizes key events regarding Employers Mutual, one of the most widespread unauthorized entities operating in recent years. Employers Mutual collected approximately \$16 million in premiums from over 22,000 people in 2001, and left more than \$24 million in unpaid medical claims.

Figure 2: Key Events of Employers Mutual, LLC from Establishment to Closure

2000	2001	2002	2003
July 28, 2000 Employers Mutual is established in Nevada. December 27, 2000 Principals begin to establish associations that had trust agreements with Employers Mutual.	January - October 2001 Employers Mutual collects approximately \$16 million in premiums from over 22,000 policyholders. January - October 2001 Employers Mutual pays principals' investment firms. May 2001 Principals establish two provider networks. June 14, 2001 Nevada issues cease and desist order against Employers Mutual. August - November 2001 Alabama, Colorado, Florida, Oklahoma, Texas, and Washington take action against Employers Mutual. October 3, 2001 Claims processing firm terminates contract with Employers Mutual. November 21, 2001 Nevada seizes Employers Mutual's assets held in Nevada banks. December 13, 2001 U.S. District Court for the District of Nevada^a grants a temporary restraining order against Employers Mutual and appoints an independent fiduciary. December 20, 2001 Nevada surrenders to independent fiduciary the Employers Mutual assets it seized.	January 2002 U.S. District Court holds hearing. February 1, 2002 U.S. District Court issues preliminary injunction. April 30, 2002 U.S. District Court issues quasi-bankruptcy order.	March 3, 2003 Independent fiduciary files civil complaint against Employers Mutual's principals and insurance agents and brokers that marketed the 16 plans. September 10, 2003 U.S. District Court issues a default judgment granting a permanent injunction against Employers Mutual. Principals ordered to pay \$7.3 million. October 20, 2003 U.S. District Court orders the civil suit to mediation in February 2004.

Source: U.S. District Court, independent fiduciary, and seven states.

Note: Includes information from the preliminary injunction, the permanent injunction, and cease and desist orders from Alabama, Colorado, Florida, Nevada, Oklahoma, Texas, and Washington.

^aAll references to the U.S. District Court in this figure refer to the U.S. District Court for the District of Nevada.

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