

HEALTH INSURANCE CHALLENGES: BUYER BEWARE

HEARING BEFORE THE COMMITTEE ON FINANCE UNITED STATES SENATE ONE HUNDRED EIGHTH CONGRESS SECOND SESSION

MARCH 3, 2004



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HEALTH INSURANCE CHALLENGES: BUYER BEWARE

WEDNESDAY, MARCH 3, 2004

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:37 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Kyl, Thomas, Rockefeller, and Daschle.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. I thank all of you for coming and the great interest there is in this problem that faces us.

I want to suggest that our hearing has at least three purposes: to expose the significant and growing problems of unauthorized and bogus health plans and their damaging effect; educating people, including employers, about unauthorized and bogus health plans, basically what they look like; and empower people with information how not to fall prey to one, and if you have already been scammed, what you should do next.

There is much to be done at the State level, at the Federal level, and by insurance companies, among others. Good-faith efforts have been made, and I commend the efforts made by the Department of Labor, the National Association of Insurance Commissioners, and the States, generally.

But at the very same time, we can, and we must, do much more to protect everyday people who are becoming victims. In other words, we need to stop bogus health insurance scams.

The problem is growing. The General Accounting Office reports that from 2000 to 2002, more than 200,000 policyholders were taken by bogus health insurance scams. Unauthorized health insurance and a bogus health insurance plan are entities that sell health insurance to individuals, unions, associations, and others with the intent not to pay claims, or at least not to pay all the claims that they ought to pay, but in most instances pay very few percentage.

This is not a new phenomenon, but a continuously growing one. Here is what I am talking about. I would like to show you a pamphlet, this pamphlet that was distributed by one of these phony health insurance plans. It is shiny, looks very official, and paints a very pretty picture.

Recently, the staff in my office received a piece of literature advertising health insurance at a very extremely low cost. This plan is even advertising that will accept people with all preexisting conditions. This came across the committee fax machine just last week.

To the average person, these two examples, and a lot of others, look like fabulous opportunities to get lots of health coverage and other benefits at very low prices. Unfortunately, these items are from phony insurance companies.

The proliferation of the Internet, the increasing number of uninsured, and the ever-increasing costs of health care make the perfect breeding ground for these scams to be born and to grow.

So, we have this hearing as a wake-up call to America and as a reminder that there are unscrupulous individuals who intentionally inflict emotional and financial harm upon businesses and individuals. We must focus on awareness, on education, and, most importantly, aggressive oversight to prevent bogus plans from taking people's hard-earned money.

Today, 43 million Americans are desperate for affordable health insurance coverage. In addition, the number of people covered by government health insurance plans is on the rise.

With more and more people being taken by these bogus health plans, the system is being pressured. More and more people will become uninsured and end up on Federal assistance programs.

Let us not forget that there are also tax and health policy implications. The predators are defrauding the taxpayers. The IRS is not able to catch. The victims are taking deductions, in other words. When all is said and done, some victims may even end up in the ranks of Medicaid.

We also need to target the scam artists who do a disservice to all the good insurance companies that are out there. On a personal note, I want to point out that no insurance company is safe from bogus health plans.

Employers Mutual, LLC, a scoundrel that scammed thousands of people, took its name from a reputable Iowa insurer, Employers Mutual Casualty Company, that has been in business in my State for 90 years. The real Employers Mutual has received more than 75 complaints from people confusing it with Employers Mutual, the scam.

By using the same of a reputable company, bogus plans aim to confuse consumers, take their money, and run. Any person taken by a bogus plan is one victim too many. It is easy to forget that there are human lives and untold stories behind statistics.

That is why we will hear this morning from a panel of everyday Americans dealing with the horrible consequences of bogus health plans. They will tell us very troubling, and all too common stories. Each has come before this committee to remind us that no one is safe from the wrath of an unauthorized health plan and the trouble that it leaves behind.

At my request, along with the request of Senators Bond and Snowe, the General Accounting Office has issued a fact report assessing the effects of unauthorized health plans.

I welcome Ms. Kathryn Allen, who will testify about the latest GAO report. The GAO report is a fact report. It is a first step in looking at this complex problem. Also, the GAO's Office of Special

Investigation will discuss the investigation of this one scam that I have already referred to.

The Department of Labor's Assistant Secretary Ann Combs is with us, too. The Department's responsibility is enforcing the Federal requirements for insurance and group plans. It found, in ERISA and implementing initiatives, ways to combat the growing problem and they see this as one of paramount importance.

We welcome testimony from the National Association of Insurance Commissioners, also from the Texas Department of Insurance, to discuss efforts to educate consumers and pursue these bogus plans. Finally, we will hear testimony from Mila Kofman about her work in this important area.

Now, I would like to say that this hearing is not about what some people might think it is. This hearing is not about association health plans, as some have asked me and members of my staff.

Legislating creation of these types of plans is not before this committee. That is before another committee that has jurisdiction. Instead, this hearing is about predators, predators who are feeding on everyday citizens across our country.

I want to close by saying that it is extremely important and valuable to maintain a dialogue among the insurance industry, regulatory agencies, Congress, and consumers and their advocates about the problems that persist.

I hope this hearing will help continue and expand that dialogue and provide a road map for what still needs to be done. We need to stop the bleeding and do it now.

Senator Rockefeller?

**OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A
U.S. SENATOR FROM WEST VIRGINIA**

Senator ROCKEFELLER. Thank you, Mr. Chairman. It was just occurring to me as you talked, and reviewing your history, when you get onto something, whether it is in the Defense Department or some kind of activity which does not please you, I think I would rather be on your side than on the other side.

The CHAIRMAN. Thank you. I would welcome that.

Senator ROCKEFELLER. The word is called relentless. Absolutely relentless.

I will put my statement in the record. I will simply say that we have a company in West Virginia which I think talks about what you are talking about, Corbin Limited of West Virginia.

Actually, they are a very prestigious company. They went bankrupt in 2004 and 444 employees were left with \$2 million in medical bills. It was solely regulated by the Department of Labor. We do things in a very, very different way in our State. So, this is a hearing of interest and importance, and I thank the Chairman for having it.

The CHAIRMAN. Well, thank you.

[The prepared statement of Senator Rockefeller appears in the appendix.]

The CHAIRMAN. Senator Thomas?

Senator THOMAS. Thank you, Mr. Chairman. I really do not have a statement. I listened very closely to yours. I have to tell you that my reaction, not knowing much about it, is that we have people

that have oversight over this thing. We have the Department of Labor, we have State insurance organizations. I really do not understand.

I think the question is, why have they not done their job? That is why you have regulatory people there. I will be very interested in knowing why they have not stepped in and done something here. It seems to me that is really the issue.

The CHAIRMAN. All right.

We have an opportunity now to hear from two people who have gone out of their way and were willing to come and tell us about the personal problems that these scam artists have caused for them and their families. We thank you for coming to tell your story.

Marie Almond and Joan Piantadosi. If I pronounced your name wrong, would you please correct the record? But I am going to term these people victims. They may want to term themselves some other way.

But they do have a very real story that you need to hear so you know what we are dealing with. The world needs to hear it because there are a lot of other people out there that these two people can be speaking for.

Would you start, Marie? Then I will go to Joan. We will let both of you testify, and then if colleagues have questions we will go to questions at that point.

STATEMENT OF MARIE ALMOND, VICTIM OF UNAUTHORIZED HEALTH INSURANCE PLAN

Ms. ALMOND. My name is Marie Almond, and I appreciate the opportunity to take part in the hearing to share my experience as a victim of a health insurance scam created and operated by Employers Mutual.

In 2001, I owned a small medical consulting firm with two other individuals. In March of that year, our company purchased a small business health insurance plan from Employers Mutual and began paying premiums.

My life quickly turned upside down in the next 4 months when I found that I had breast cancer in July. I was devastated and suffered tremendous emotional stress. Unfortunately, my stress would only compound itself when I realized Employers Mutual was not paying my claims.

To date, there are outstanding medical bills of \$71,000 that I incurred on procedures related to my breast cancer, my treatment, and other medical emergencies during the time that Employers Mutual should have been paying the claims.

Soon after discovering that I had breast cancer in July of 2001, I underwent surgery, chemotherapy, and radiation treatment. As expected, these procedures are very costly, totaling \$65,000.

As soon as I received my medical bills, I sent them to Employers Mutual for payment. Acting under the facade of a legitimate health insurer, Employers Mutual promptly responded by sending me a notice that the claims were being processed.

Since Employers Mutual was purporting to be a legitimate company and there was no indication at that time it was operating a health insurance scam, I believed that in the future these claims would be paid.

Unfortunately, I would soon learn that Employers Mutual's claims of processing my bills were nothing more than a front to buy time for the company to receive premiums.

I distinctly felt that something was wrong, and I learned that the medical bills had not been paid during the next 3 months. Clearly, it did not take that long to process claims.

I desperately needed answers, so I contacted the Tennessee Insurance Commissioner's office to find out about Employers Mutual. To my horror, I learned that Employers Mutual was a Nevada company and not licensed to sell insurance in Tennessee. My heart sank.

Still needing answers to my questions about Employers Mutual, I decided to contact the Nevada Insurance Commission's office to learn more. I learned that the State of Nevada had ordered Employers Mutual to stop operating its scam business.

Unfortunately, I soon learned that I had another problem with Employers Mutual which would escalate when my doctor said I needed to have another procedure immediately.

My doctor strongly recommended that I receive the treatment in the hospital in Germantown, Tennessee. I feared that I would ultimately be responsible for paying for this procedure.

The hospital subsequently refused to admit me because of outstanding medical claims related to my breast cancer. With no other option, and as a last resort, I reluctantly agreed to have a procedure performed in the physician's office. I simply had no other choice.

My frustrations with Employers Mutual mounted because the cost of the procedure was \$6,000, and I was at my wit's end. All during this time, Employers Mutual continued to purport that it was a legal health insurance provider, claiming that my outstanding claims, now of \$71,000, were being processed.

Employers Mutual carried on this charade to January of 2002. However, the curtain fell on January 21, 2002 when the company finally admitted that a temporary restraining order had been issued against it and told me that I would not receive any benefits until the lawsuit against them had been resolved.

At my age, the prospect of not being insured is daunting. As a small business owner, I knew the cost of coverage for my business would be exorbitant, yet I needed insurance and I needed it quickly. With no other recourse, I had to leave the company that I started and go to one of my company's competitors just to get insurance.

I cannot begin to explain the emotional turmoil that I suffered when I left the company that I started, forging meaningful relationships, just to obtain health insurance. To me, I was paying the ultimate price for Employers Mutual's scam operation.

Between January 2002 and October 2002, I was uninsured. Fortunately, there were no medical emergencies at this time. If there had been, I would have been financially responsible for them. As of October, 2002, Blue Cross/Blue Shield of Georgia became my insurer.

After experiencing Employers Mutual, I was happy to be insured by a reputable company. However, for almost a year I feared that I would be financially responsible, until my preexisting coverage with Blue Cross/Blue Shield. These fears subsided in November of

2003 when Blue Cross/Blue Shield began paying the claims associated with my preexisting condition.

I would like to thank you for the opportunity to share my experience, and I would be happy to answer any questions.

The CHAIRMAN. Do you realize that you are one of the few witnesses that finish right at the bell? [Laughter.]

Ms. ALMOND. That is a good sign.

The CHAIRMAN. Yes.

Now, Joan, would you proceed, please?

STATEMENT OF JOAN PIANTADOSI, WIFE OF ALBERT PIANTADOSI, VICTIM OF UNAUTHORIZED HEALTH INSURANCE PLAN

Mrs. PIANTADOSI. Mr. Chairman and members of the committee, my name is Joan Piantadosi. As a victim of the health insurance scam created and operated by Employers Mutual, I appreciate the opportunity to take part in this hearing.

In 2001, I was paying insurance premiums on behalf of my family and employees to Employers Mutual, believing it was a legitimate health insurer. During that time, my husband experienced a medical trauma resulting in the need of a liver transplant.

During this time, the medical trauma was exacerbated by emotional turmoil when we discovered that Employers Mutual was not a legitimate insurer. Due to the company's failure to pay our medical claims, there are more than \$500,000 in unpaid bills for my husband's medical care.

Our story began in July, 2001 when insurance agents contacted me regarding a health insurance plan being offered by Employers Mutual. According to one of the agenda, I could save 30 percent on my health insurance. The agent told me that the insurance was offered through several associations composed of thousands of individuals whose group associations entitled them to very low rates.

Upon learning of an impending rate increase by Humana, and that Employers Mutual premiums would be significantly lower, I decided to switch coverage from Humana to Employers Mutual on behalf of my family and two employees and our family business.

On August 1, 2001, I began paying premiums. In November of 2001, my husband began experiencing severe neck and shoulder pain. Our doctor referred us to an orthopedic surgeon, who administered an epidural in an attempt to provide some relief.

Employers Mutual pre-approved the epidural, as well as the office visits to our doctor and the orthopedic surgeon. When the epidural failed to alleviate my husband's neck and shoulder pain, he began taking over the counter pain relievers.

Unbeknownst to us, the painkillers aggravated his preexisting liver condition. We would learn afterwards that, over the course of a few weeks, my husband's already poorly-functioning liver would shut down completely.

Before the liver problems became apparent, the orthopedic surgeon thought that my husband would benefit from another epidural for his neck and shoulder pain. For several weeks, I tried in vain to reach someone at Employers Mutual to obtain pre-approval for the procedure.

When I finally spoke with an Employers Mutual representative on December 19, 2001, I was referred to a court-appointed fiduciary. To my alarm, I was advised the company was shutting down and would not pay any claims submitted after December 31, 2001.

Armed with a letter from the court-appointed fiduciary, we were able to get the second epidural on December 21, 2001. On Christmas Eve, my husband slipped into a coma due to complications from the failing liver. On Christmas Day, he underwent a 12-hour surgery at a Ft. Lauderdale hospital. On New Year's Eve, after 6 days being comatose, my husband regained consciousness.

The doctors informed us that he needed to be evaluated to determine whether a liver transplant would be possible. The evaluation had to be conducted in Miami at Jackson Memorial Hospital. However, the hospital would not admit him until Employers Mutual pre-approved payment for the medical bills.

Again, I had to find a way to hold Employers Mutual accountable. First, I personally attempted to obtain pre-approval for the transplant evaluation from the court-appointed fiduciary. When those efforts were unsuccessful, I had my attorney telephone the fiduciary on behalf of my husband and myself. Understandably, we were desperate.

On January 11, 2002, the court-appointed fiduciary sent a pre-approval for the transplant evaluation. However, the pre-approval did not guarantee payment. My husband was admitted to the hospital on January 12, 2002. He stayed there for 2 weeks while an evaluation was conducted.

After being told he would be placed on the transplant recipient list, he was sent home. In early February of 2002, we were informed that since the lack of insurance coverage, we would have to pay a deposit of \$150,000 before my husband could enter the hospital liver transplant inpatient program. We simply did not have \$150,000 to cover the deposit. Consequently, my husband was removed from the recipient list.

Like the preceding months, the next 2 weeks were an emotionally tumultuous time for us. We feared, among other things, that my husband might die while we were attempting to deal with the predicament of being uninsured, despite having paid premiums to what appeared to be a legitimate health insurer.

Fortunately, our story ends on a positive note. First, Eileen Lieberman, a Broward County commissioner, intervened on behalf of my husband and he was placed back on the transplant recipient list. Second, we were able to obtain new insurance in February of 2002 which took effect shortly after on March 1, 2002. Third, and most importantly, my husband underwent a successful liver transplant on April 10, 2002. Thankfully, the new insurance company covered the surgery.

Again, thank you for giving us the opportunity to share our experience with you concerning the health insurance fraud. I would be happy to answer any questions you might have. Our medical bills during this time period exceeded \$800,000.

Bills of about \$500,000 were incurred during the time that Employers Mutual should have provided coverage, and remain unpaid. Although our new insurance company covered \$300,000 of medical bills, we were saddled with personal debt that totaled \$33,000 for

medical expenses incurred while we were without any type of insurance from January, 2002 to March, 2002.

Thank you for the opportunity to be here.

The CHAIRMAN. Thank you, Joan and Marie.

We will take 5-minute turns for questions.

I only have two questions. I think they would come into the category of not necessarily getting new information from you, but highlighting some things that you have said. I would like to have both of you to answer both of the questions.

Once you found out that your health insurance was a scam, did you know who to call in your State or the Federal Government? Did you have any idea of what to do? And if you did not, where did you get the information to pursue what you have told us about?

Ms. ALMOND. Well, I have been in the health care industry for 30 years, so I just instinctively knew to call the commissioner in Tennessee.

The CHAIRMAN. All right.

Ms. ALMOND. I am not sure that I would have known that if I had not been in health care.

The CHAIRMAN. All right.

And you, Joan?

Mrs. PIANTADOSI. No, I did not know who to call. What I did, was I sent a telegram to my President and I cc'd it to my Governor of Florida. Through that, I was fed information on who to call in Tallahassee, the Insurance Commission, and in Ft. Lauderdale. But through that telegram, I was led in the right direction.

The CHAIRMAN. Now I would like to have each of you take a moment, because of your experiences with this problem and how it highlights the problem that is before this committee and the Congress, and even before our States, and even for something for legitimate insurance companies to help us stay on top of, and tell us, what advice would you give people across the country if they, like you, are victimized by bogus health plans, based upon your experience?

Ms. ALMOND. I would go to the State insurance commissioner. The thing that always has bothered me, or bothered me, is I got an agent. An agent actually came to our office and sold us this plan. Well, you go to an agent because they are supposed to know what they are doing.

The CHAIRMAN. Is there anything about your initial purchase from the scam company you bought insurance from that you see now as something that alerted you to the fact that it was a scam as opposed to the real thing that you can tell us that people might look out for?

Ms. ALMOND. Well, the low cost. We paid, for three people, \$800 a month.

The CHAIRMAN. One of the rules is, if it is too good to be true—

Ms. ALMOND. It probably is.

The CHAIRMAN. Yes.

Joan?

Mrs. PIANTADOSI. Well, my advice to the consumer would be to call their insurance commission. If they are dealing through an agent, get the agent's name and all of their information, the insurance policy, and call and just make sure it is legitimate, because

the packages that are sent out, the faxes that are sent over, look real, sound real, and there is a human being on the other end of the phone telling you it is real. So, I would check it out with the insurance commissioner of your State.

The CHAIRMAN. All right.

Senator Rockefeller, then Senator Thomas.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

An observation, and one question to you, Ms. Piantadosi.

Mr. Chairman, it just amazes me that we talk up here about people having health insurance problems, and so much of it is generic or in the abstract because we do not have people specifically before us.

We have our constituents that come to see us, but often they do not bring their health problems to us or they do not want to come to Washington to do that. They cannot afford to come to Washington to do that.

It just strikes me how many folks there are out there, not the 44 million uninsured that we always talk about, but how many folks that are out there who are trying to make things work, run up against a catastrophe. Eight hundred thousand dollars? I mean, good grief. That is why a hearing like this is very, very, very important to us.

The question I wanted to ask you, is I was very interested by your response because in your second answer to the Chairman's question you said, well, I contacted the insurance commissioner of the State, which would be a very good thing to do.

Your first response was that you telegraphed, I think, your Governor and the President. That, to me, was very interesting. That is what a lot of people do. I was a Governor for 8 years and people get in touch with your office.

In a small State like the one I come from, they think that, well, that means the next day they will get something back in the mail, if not a personal phone call. But life does not usually work like that.

So the question I have for you is, how long did it take you to hear from your Governor and from the Office of the President? I do not care who sent the response, but that gave you the information which you said was helpful. How long?

Mrs. PIANTADOSI. I would say about 10 days, I got the first phone call.

Senator ROCKEFELLER. Well, that is fast. I am surprised by that.

Mrs. PIANTADOSI. It could have been sooner, but I will say, in about 10 days I got a call.

Senator ROCKEFELLER. Where do you come from?

Mrs. PIANTADOSI. I come from Massachusetts, but I have resided in Florida for 21 years.

Senator ROCKEFELLER. Well, those are two rather large States.

Mrs. PIANTADOSI. So, it is a mix.

Senator ROCKEFELLER. All right. Well, they are well-run, I guess. All right. Thank you very much.

The CHAIRMAN. Senator Thomas?

Senator THOMAS. Well, thank you both. Certainly those are very, very difficult situations that you found yourself in.

Do you believe, if there is an insurance company/policy operating in your State, they should be legitimized, that they should be registered, that they should be authorized to be there?

Ms. ALMOND. Yes.

Senator THOMAS. And whose responsibility do you believe that would be?

Ms. ALMOND. The State.

Senator THOMAS. The insurance commissioner, would you not imagine? Is that not what it is for?

Ms. ALMOND. The insurance commissioner of the State.

Senator THOMAS. And what about you? Do you think that there should be some entity that says, if you are going to operate in our State—you indicated your insurance companies were not legitimate. You indicated they were a scam. So, would you not think they ought to have been reviewed before they could operate there?

Mrs. PIANTADOSI. That was one of my questions when I found out, why was I not told, or why does the consumer not know that these people were not licensed.

Senator THOMAS. Why are they even there?

Mrs. PIANTADOSI. I was told they were licensed in Florida and there was a cease and desist. But that was not sent out to the consumer.

Senator THOMAS. Cease and desist to what, do you know?

Mrs. PIANTADOSI. Yes. Cease and desist for them to sell the insurance in the State of Florida.

Senator THOMAS. But they were still selling it?

Mrs. PIANTADOSI. Yes.

Senator THOMAS. Thank you. No more questions.

The CHAIRMAN. All right.

Our Democratic Leader just came. I want to give him a chance, before you leave the table, if he wants to ask you some questions. You have gotten a chance to get settled. Just get your breath.

Senator DASCHLE. Thank you, Mr. Chairman. I will. I appreciate your kindness, but I will allow the testimony to go forward. I do not have any questions at this particular time.

The CHAIRMAN. What I would do then, is thank you. But I am going to put in the record, and also I hope it is in our packet that we put out at the tables, I have got seven tips. I do not know whether there is any magic number about seven tips. It could be 10. Maybe you folks that are victims could add another 20 to it.

But I have seven tips here to avoid being a victim of a health insurance scam. I will put them in the record. I am not going to take time to read them now. So, at least minimally, people will have something to check against if they have any questions about this.

[The information appears in the appendix.]

The CHAIRMAN. So, I thank you.

I am going to call the next panel. While the next panel is coming, again, we usually give the courtesy of a statement to the Leaders if they have to come and say something and run. We understand. If you want to go ahead now, I would be glad to have you go ahead now.

**OPENING STATEMENT OF HON. TOM DASCHLE, A U.S.
SENATOR FROM SOUTH DAKOTA**

Senator DASCHLE. Mr. Chairman, thank you very much. I know that this is a busy day for you, too, because you have a bill on the Senate floor. But I want to commend you for calling this hearing.

I think it is really one of the most important short-term issues that this committee and the Congress has to address. I look forward to having more time to examine the GAO's findings and conclusions and to hearing more from the other witnesses that we have before us today.

I especially want to thank the victims of these scams for coming forward, as they have this morning. There is no doubt that we face some extraordinary challenges with regard to health care.

I cannot go home and not hear from people who have lost family members because of extraordinary medical problems that could not be addressed because they did not have the resources, double-digit increases in the cost of health insurance, businesses having to make difficult choices between literally dropping employees or paying for higher costs for benefits. So, there is no doubt that we have some very serious problems.

But, based on the GAO prepared testimony, it is clear that the Department of Labor, the States, and the NAIC have some very major challenges to address as we look to the scams that are now in existence as a result of efforts being made to thwart the enforcement of sound regulatory policy.

The important roles that States play in regulating insurance is one of the reasons that I think we need to oppose legislation to exempt the association health plans from State regulation.

The National Governors Association, the National Association of Insurance Commissioners, represented here today by Wisconsin's Fred Nepple, the National Associations of Attorneys General, and virtually every other State-wide organization has come out in opposition to this exemption.

I think we need to take this opportunity to explore what we can do to strengthen both our State and our Federal prevention and enforcement efforts, and I really look forward to opportunities that this testimony will afford us in looking more carefully at options available in public policy.

But, again, Mr. Chairman, I appreciate your interest in holding this hearing and look forward to the testimony this morning from the witnesses who have come.

The CHAIRMAN. Your statement gives me a chance to highlight something I said in my opening comments that you would not have had a chance to hear.

It happens that I am making a special point to make clear to everybody that this is not a hearing about association health plans, this is about scam artists, and mostly because associated health plans are under the jurisdiction of the other committee, the Health Committee. So, just to clarify, we are not getting into that. Thank you, Mr. Leader.

We have Kathryn G. Allen, Director of Healthcare—Medicaid and Private Health Insurance Issues of the U.S. General Accounting Office. This report that is going to be released today was asked for by Senators Bond and Snowe as well.

Then we have Robert Cramer, Managing Director, Office of Special Investigations of the U.S. Accounting Office. Then we have Ann L. Combs, Assistant Secretary, Department of Labor, Washington, DC.

I have got longer introductions for you that I am going to put in the record. You are very important people. Particularly, as you know, Ms. Allen, I rely very much on your agency to help in the oversight that we do. So, we thank you for doing your good work, and particularly reporting today. Go ahead.

[The information appears in the appendix.]

**STATEMENT OF KATHRYN G. ALLEN, DIRECTOR,
HEALTHCARE—MEDICAID AND PRIVATE HEALTH INSURANCE
ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC**

Ms. ALLEN. Thank you, Mr. Chairman and members of the committee. It is a pleasure to be here today as you address this very important topic of how employers and individuals who are seeking affordable health coverage have been exploited by unauthorized or so-called bogus entities selling health benefits.

With the double-digit premium increases in the past few years, lower-priced policies that appear to provide comprehensive coverage can seem very attractive to those seeking affordable coverage.

But, Mr. Chairman, as you have already said this morning, if low premiums seem to be too good to be true, they probably are. These unauthorized entities typically begin to market their plans and they begin to collect large amounts of premiums in their early phases, and they pay some small claims at first so as not to arouse suspicion.

But before long, as we have already heard, they begin to delay, and they ultimately default on, payments of large amounts of legitimate medical claims, often in the millions of dollars.

When this happens, many parties are harmed. This includes the policyholders themselves and their family members, who can end up with thousands of dollars in unpaid bills; employers, who found that they have paid much in premiums for non-existent coverage for their employees; and health care providers themselves, who are at increased risk of not being paid for services they have already rendered.

My remarks today will summarize the findings of the report that is being released today. Our findings are based on our survey of the insurance departments of all 50 States and the District of Columbia, as well as our work with the Department of Labor and with selected States.

My remarks will address three issues: the extent of the problem nationwide, characteristics that some of these unauthorized or bogus entities have in common, and, finally, actions that State and Federal Governments have taken to identify and stop these entities from spreading.

My colleague, Mr. Cramer, will then elaborate on how many of these issues have played out in one of the most problematic entities that we have already heard about this morning, Employers Mutual.

First, from the year 2000 to 2002, the States and the Department of Labor identified 144 unique or different entities nationwide that were selling health benefits coverage, although they were not licensed by the States and they were not authorized to provide coverage.

The harm caused by these entities was extensive. These 144 entities covered at least 15,000 employers and about 202,000 policyholders nationwide. This covers far more lives than the 202,000, because often policyholders represent more than one individual.

At the time of our work, these entities had left more than \$250 million in medical claims unpaid, only about 20 percent of which had been recovered on behalf of policyholders.

The harm was, indeed, widespread and growing during this 3-year period. Every State was affected, with at least five entities operating in every State in the Nation. Seven States had 25 or more entities operating within their borders.

The number of unauthorized entities doubled during the period of our review, from 31 identified in the year 2000 to over 60 new ones identified in 2002.

Second, the entities took various steps to enhance their appearance of legitimacy. Some used names similar to well-known firms in order to appeal to individuals' good faith in established, reputable businesses.

These entities often marketed their products through licensed agents and they often established relationships with networks of health care providers or other companies that provide administrative services for employers.

To increase their attractiveness, they typically set their premiums well below market rates and they market to employers and individuals, including small businesses who are likely to be seeking affordable health coverage.

They often appeal to individuals in industries or professions that are more likely to be uninsured, such as the construction or transportation industries.

Third, and finally, the unauthorized entities often characterize themselves in a way to give the appearance of being exempt from State regulation. States, however, in reviewing these operations generally found them to in fact be subject to State regulation, which enabled them to then take action against them.

Once identified, the States and Department of Labor, both individually and collaboratively, took action against these entities and sought to increase public awareness to prevent their spread.

For example, State insurance departments issued cease and desist orders which commanded them to essentially stop operation for more than 40 of these entities. However, these cease and desist orders typically apply only to entities operating within individual State borders.

States also have filed civil and criminal cases and they have fined or revoked the licenses of agents who received commissions from marketing these entities. During this period, the Department of Labor also obtained court orders to stop the activities nationwide of three large entities, each of which was operating in more than 40 States.

In closing, Mr. Chairman, it is clear that increased demand for more affordable health coverage has created an environment ripe for exploitation. As a result, too many employers and individuals have paid far too much for non-existent health care coverage.

In such an environment, it is important that the Federal and State governments work together to remain vigilant to prevent, identify, and stop these entities from operating.

They must also continue to urge individuals, employers, and insurance agents to verify the legitimacy of these entities offering coverage before committing to purchase their products.

Mr. Chairman, this concludes my prepared statement.

The CHAIRMAN. Thank you, Ms. Allen.

[The prepared statement of Ms. Allen appears in the appendix.]

The CHAIRMAN. Now, Mr. Cramer?

**STATEMENT OF ROBERT J. CRAMER, MANAGING DIRECTOR,
OFFICE OF SPECIAL INVESTIGATIONS, U.S. GENERAL AC-
COUNTING OFFICE**

Mr. CRAMER. Good morning, Mr. Chairman and members of the committee. Thank you for the opportunity to appear here today to summarize some of the evidence that the Office of Special Investigations at GAO has gathered concerning Employers Mutual, which was one of the most widespread of the 144 unauthorized companies we know of that have recently sold bogus health insurance to the public.

Four individuals, who I will refer to as the principals, operated Employers Mutual during the year 2001, collecting about \$16 million in health insurance premiums in every State of the Union and the District of Columbia from over 22,000 people.

Today, Employers Mutual, which is under investigation by law enforcement authorities, has been shut down. There are, however, more than \$24 million in health insurance claims against Employers Mutual that have never been paid.

Following the pattern of companies that offer bogus health insurance, Employers Mutual, as has been mentioned, took the name of a well-established Iowa insurance company, which of course had absolutely no connection with Employers Mutual.

Notably, both in 1998 and again in 2000, one of the principals of Employers Mutual was barred from conducting any insurance business in the State of California, having been found to do so on two occasions without authorization. Nevertheless, Employers Mutual set up two offices in California and essentially operated its business within that State.

Again, following the pattern of those who offer bogus health insurance plans, two of the Employers Mutual principals formed 16 associations that had names that covered workers in a wide array of industries and professions, such as farmers, construction workers, mechanics, and food service employees.

Employers Mutual principals were named as the managing members of these associations and created on paper health insurance plans for workers who would join these associations.

The principals contracted with legitimate firms to market these plans to employers nationwide. Employers Mutual did not obtain

State licenses to operate health insurance businesses and claimed that it was exempt from regulation by the Department of Labor.

One of the principals, who was not a licensed actuary, had no formal training, set the premiums for the 16 associations by going online and calculating the average rate charged by insurance companies and reducing them so that Employers Mutual, of course, offered the lowest prices.

The principals also formed two companies that purported to provide networks of health care providers for people insured by Employers Mutual. At least one of them had no employees and provided absolutely no services, but was paid hundreds of thousands of dollars by Employers Mutual.

Additionally, the principals formed two other companies which purported to provide investment services for Employers Mutual. However, all four of these companies were found by the District Court in Nevada to be vehicles to illegally divert premiums.

Over here on the right is a chart, the one labeled "Proceeds of Employers Mutual Insurance Scam." It gives a general idea of the flow of the money. On the very bottom of it, there are 16 little boxes representing the 16 associations that were formed.

There is a line going up with the box in the middle showing approximately \$16.1 million that Employers Mutual received. The other four bottom boxes show actual legitimate expenses that were paid by Employers Mutual. They did pay out \$4.8 million in insurance claims and they did pay \$1.4 million to insurance agents, brokers who sold the insurance, as well as about \$600,000 for claims processing.

The upper part of the chart shows the ill-gotten gains here. There are four boxes in the upper portion of the chart. Those are the four companies that the principals formed to illegally divert proceeds of the insurance plans. Then, at the top, the four principals were ordered by the District Court in Nevada to pay over \$7 million which documents showed had been diverted to them.

When the Nevada insurance regulators became aware of Employers Mutual, they issued a cease and desist order in June of 2001. Other States subsequently also issued cease and desist orders against Employers Mutual.

In December of 2001, based on a petition from the Department of Labor, the U.S. District Court for the District of Nevada granted a temporary restraining order against the company and its principals, freezing their assets and prohibiting them from conducting further business.

Just to sum up, in addition to Joan Piantadosi and Marie Almond, the two victims who testified here, there are thousands of other victims of Employers Mutual. In our interviews of those victims, we have heard tales of sickness, shock at the discovery that there was no health insurance, debt, ruined credit histories, and sometimes personal bankruptcies, and, of course, anxiety that made a sickness far worse than it should have been simply because people were buying what turned out to be illusory health insurance from Employers Mutual.

Thank you for the opportunity to testify.

[The prepared statement of Mr. Cramer appears in the appendix.]

The CHAIRMAN. I want to wait for questions. But did anybody go to jail because of this, or is this not considered criminal activity?

Mr. CRAMER. There is a pending criminal investigation by the authorities ongoing at this point in time.

The CHAIRMAN. All right.

Ms. Combs?

**STATEMENT OF ANN L. COMBS, ASSISTANT SECRETARY,
DEPARTMENT OF LABOR, WASHINGTON, DC**

Ms. COMBS. Thank you. Good morning, Chairman Grassley, Leader Daschle, and members of the committee. Thank you for inviting me to testify today on behalf of the Department of Labor's Employee Benefits Security Administration, which has administered the Employee Retirement Income Security Act, or ERISA, for 30 years.

The CHAIRMAN. Can I interrupt you for just a minute?

Ms. COMBS. Certainly.

The CHAIRMAN. I am going to have Senator Kyl take over because I have to go to the floor to manage the FSC/ETI bill. So, I am going to excuse myself. I will submit questions for answer in writing.

Ms. COMBS. Thank you. And thanks, again, for the opportunity to be here.

The CHAIRMAN. Thank you very much. Just proceed.

Ms. COMBS. All right. Thank you.

I would like to ask that my full statement and the educational materials that we have produced be included in the record.

[The prepared statement of Ms. Combs appears in the appendix.]

Ms. COMBS. ERISA has successfully encouraged the development of quality employment-based health benefits for most Americans, but despite its overall success, small businesses and self-employed individuals remain vulnerable to insurance fraud.

In my testimony today I am going to highlight what DOL, and in particular the Employee Benefits Security Administration, are doing to protect small businesses, workers, and their families.

As we have heard from today's very compelling witnesses, insurance scams come with profound human costs. All too often, victims of health insurance scams discover they have been lied to when facing pressing health needs.

It is only after they have received care and the hospital or the doctor bills them for the full amount, or that they have requested approval of a medical procedure when they informed that they have no insurance, that workers are made painfully aware that they have been defrauded.

A major illness or surgery can cost hundreds of thousands of dollars. These situations devastate workers and their families, threatening their financial security. There is no higher priority at the DOL than finding the people who perpetrate these scams and shutting them down.

Health insurance scams typically occur when a corrupt promoter falsely promises low-cost health insurance coverage, collects premiums from unwitting businesses and workers, and then fails to make good when the claims are filed.

Given the high cost of securing coverage and market conditions that put them at a disadvantage, small employers and workers in small businesses are the most vulnerable to these scams.

In this environment, it is no wonder that health insurance scam artists can find small employers who are willing to jump at what looks like a great deal, but which turns out to be, as the Chairman said, too good to be true.

In practice, many of these scams are multiple employer welfare arrangements, or MEWAs, under the statute. MEWAs are entities that provide health benefits to employees of two or more unrelated employers who are not parties to collective bargaining agreements.

States and the Federal Government jointly regulate MEWAs. While States can require MEWA operators to be licensed and can oversee their financial soundness, the Department of Labor enforces our fiduciary provisions, which require them to prudently handle any plan assets and act in the sole interest of the plan beneficiaries.

In addition to DOL and the States, other Federal agencies such as the Justice Department and the National Association of Insurance Commissioners are involved in our enforcement efforts.

I am proud of the hard work and the cooperation all of the agencies, both State and federal, have demonstrated in our efforts to prevent, investigate, and prosecute individuals who prey on vulnerable workers and their families.

DOL takes a three-pronged approach to stopping health insurance scams. First, we focus on prevention by educating employers and consumers so that they can avoid being taken advantage of.

Second, we aggressively pursue civil and criminal enforcement actions, working with the States and the NAIC to shut them down. Third, we support legislation to create a secure and affordable alternative for small businesses so that they can find health insurance that is secure and that will pay benefits when they are due. That is the association health plan legislation.

First, let me focus on prevention. We work hard to educate purchasers of insurance. Secretary Chao personally provided detailed guidance and a fact sheet with tips on how to avoid being taken advantage of to over 80 leaders of America's small business community and asked them to distribute that information to their memberships.

We also publish and distribute educational materials explaining the law and Federal and State regulation of MEWAs, and we have guidance for workers on what to do when their claims have not been paid or they lose their coverage.

All of these materials are available on our Web site and are distributed in outreach sessions that we hold with consumers, small employers, service providers, and insurance commissioners throughout the country.

The second prong of our approach is enforcement. We conduct thorough investigations, exchange relevant information with States and other Federal agencies, file civil complaints, and bring criminal indictments.

From 1990 through December, 2003, we have conducted 621 civil, and 107 criminal investigations of health plans that have affected

nearly 2 million participants and their families, and we have identified violations involving almost \$140 million.

Over the years, DOL and the States have developed strong working relationships. We exchange case-specific information regarding ongoing investigations on a regular basis. We participate in NAIC quarterly meetings to exchange information about health issues that are of concern to the regulators, and our staffs meeting informally whenever the need arises.

Our field offices also regularly conduct MEWA training sessions with outside agencies to discuss investigations. For example, our Atlanta and Dallas regional offices sponsored a conference recently with nearly a dozen regional State representatives to discuss these issues.

We also have made presentations to the FBI's Health Care Fraud Task Force regarding these issues, and we conduct a training session for them at their Federal center in Glenco.

We undertake projects such as these on an ongoing basis to keep our investigators and the other regulators that we work with up to speed on the latest issues and, as I said, to share information about cases.

When we uncover a corrupt situation, we seek a temporary restraining order from a Federal court to freeze the assets of both the insurance operation and its promoters. The goal is to shut them down.

We work closely with State insurance departments and the NAIC, and we typically ask the court to appoint an independent fiduciary, who then takes charge of the plan, marshals the assets for the payment of claims, and works to hold individuals personally liable for losses.

We share our investigative findings with the States to help them obtain the cease and desist orders that they can get to deal with operations within the borders of their States.

Cooperation has been crucial in the investigation of Employers Mutual. I was going to discuss that, but Mr. Cramer has gone through that today. We were very involved in that, including getting the temporary restraining order, asking the court to appoint an independent fiduciary, and we were successful getting a judgment in the Federal court in Nevada, ordering the principals of Employers Mutual to pay \$7.3 million in losses.

Since that time, the independent fiduciary has established that the losses totaled \$26 million, and the Secretary will amend her request for the court to increase the judgment to cover the full amount.

We also stand ready to assist the States and the independent fiduciary, both of whom have ongoing actions against the over 303 agents who sold these policies, to recover additional monies for the victims of this abuse.

Health insurance scams threaten the economic security and the health of America's workers and small businesses. Insurance failures, as we heard this morning so graphically, hurt real people who simply cannot absorb these large-dollar losses. We always remember that our job is not about statistics. Our mission is to protect hardworking Americans and their families.

We are committed to shutting down these health scams and stand ready to work with Congress to expand access to affordable, quality health insurance that has rigorous protections from fraud and abuse and strong enforcement provisions as well so we are able to make sure that promises that are made to people about their health insurance are kept.

Thank you for the opportunity to testify today and for allowing me to go over my time. I look forward to your questions.

Senator KYL. Thank you, Ms. Combs.

Senator Rockefeller may have to leave shortly, so if it is all right with Senator Thomas, I will call first on Senator Rockefeller, then Senator Thomas.

Senator DASCHLE. Thank you, Mr. Chairman.

In West Virginia, the State insurance commissioner, which is not a particularly large office, closely monitors, as do you, Ms. Combs, every health insurance company for small employers, which is what an AHP is.

For example, they require every insurer to submit information every quarter on their financial status. They follow up with on-site audits. If an insurer does not meet our financial standards, the State works out a plan of recovery to make sure that funds are available to pay consumers and providers.

The commissioner also can, and has in the past, taken over management of the insurance company to protect consumers. So, that is one side.

Now, my understanding is that AHPs are essentially self-reporting with respect to the Department of Labor. DOL is not expected in the legislation to be a proactive regulator. The AHP is, in fact, itself, to notify the Department of Labor when they have a problem, which could take months, or more.

I do not understand. Since when have we relied on insurance companies to regulate themselves, if I am correct? I would think that you would be concerned about consumers joining AHPs because, in effect, the history has been one of health claims not being paid. Then all of a sudden you are getting asked by the public, by the Congress, and others, what happened? Why were you not more accountable to the public?

Ms. COMBS. Well, first, AHPs can offer fully insured products, and we expect that many of them would. If they offer a fully insured product, that insurance product would continue to be regulated and overseen by the States. So, we envision a very active role for the States in continuing the work that they do in overseeing insurance products.

The legislation does also allow for self-insured AHPs, similar to self-insurance that is available to large employers and collectively bargained plans. That would be overseen by the Department of Labor.

There are several provisions in the legislation that we believe would work to prevent the kinds of situations we have seen like Employers Mutual. First, and importantly, every association health plan, whether insured or self-insured, would be required to file a certification with the Department of Labor.

One of the big problems that we have—

Senator ROCKEFELLER. You mean, certification at the beginning of their existence?

Ms. COMBS. Exactly.

Senator ROCKEFELLER. What about along the way?

Ms. COMBS. They have to file annual reports. But we know who they are. One of the big problems with the current situation, with employers mutual and others, has been—and I think you will hear this from the States as well—that we are always coming in after the fact after we hear complaints from consumers, because these people, frankly—not to put too fine a point on it—are crooks.

They are not licensed by the States. They do not sign up. So, we will know and will be able to isolate who they are and they will be a viable alternative.

Association health plans will be required to register with the Federal Government. We will keep a list and they have to file annual reports.

They do have to have a qualified actuary who has to certify then to us, with penalties that are associated, about their reserves, their solvency, and their claims-paying ability. There would be, for the first time, Federal solvency standards for self-insured health insurance. There is no such thing now under ERISA. So, association health plans would have solvency standards.

There would be a requirement that they have stop-loss insurance and there would be a fund created which would require all association health plans to pay a premium so that, in the event one went insolvent, the premiums for the stop-loss insurance would continue to be paid so we could pay out that tail of claims that was in the pipeline and had yet to be filed.

The legislation also gives us the ability to contract with State insurance departments or others, as needed, to make sure that the requirements of the legislation are being met.

Senator ROCKEFELLER. Would the AHP be required to report to you if they are having any difficulties at all?

Ms. COMBS. There are reporting requirements on an annual basis. If there are situations where there is a precipitous spike in claims or a drop in reserves, they do have, I believe I am correct, reporting requirements. But we can certainly fill that in for the record what, specifically, the cycle is on reporting.

Senator ROCKEFELLER. The annual basis thing would worry me a little bit. A lot can happen in a year.

Ms. COMBS. Certainly, one of the things, as I said in my testimony, we view the legislation as creating a viable, secure alternative. It is one of the reasons it is so important, is the reason people become victims of these horrible scam operators, is they are vulnerable. They are looking for affordable health insurance and they are taken in.

We really need to work together, I believe, to create a secure, sound alternative. We want to work with the States and with you, obviously, to make sure that the association health plan legislation has sufficient protections and sufficient penalties included in it so that we can avoid these kinds of situations.

If we can get to a position where people either buy the fully insured product or they have to buy product from something that is

regulated by the Federal Government, we can isolate and put the bad actors out of business and dry up the demand.

Senator ROCKEFELLER. Real quickly. Do you have any concept of how many people you actually have working full-time on this matter in the Department of Labor?

Ms. COMBS. Well, we have, right now, 930.

Senator ROCKEFELLER. On only this problem.

Ms. COMBS. Only on MEWAs? We have a MEWA coordinator in each region—we have 10 regions—whose job is to solely coordinate the efforts. But both of our enforcement staffs work on this on an ongoing basis, and we have about 600 people, in general, who work on enforcement. They are not dedicated solely to MEWAs or the health insurance scams. But we do have a coordinator in each office whose sole job is to coordinate that.

We also have benefit advisors. If I can just beg your indulgence. We have over 100 benefit advisors around the country who deal with individuals who call us with concerns or complaints.

When we see a pattern of complaints about one insurer, that will trigger an investigation. That is when we go in. We currently have 130 open cases right now, civil cases, and another 28 criminal cases, looking at these scams. It is a very high priority for us.

Senator KYL. Thank you.

Senator Thomas, do you have any questions?

Senator THOMAS. Just very briefly.

Ms. Allen and Mr. Cramer identified some of the problems there, 144 different things in every State. Yet, you have talked about how great a job is going on here. I do not understand that. It does not seem to me like whatever is happening is working.

There has to be something more, particularly between States. So, I guess I am asking you, why are you so optimistic about what you are doing when this is the result?

Ms. COMBS. Well, I would not say I am optimistic. I think we work very well cooperatively and we have done a good job, given the tough situation.

Senator THOMAS. I am talking about results. I am not talking about how cooperative you are. I am talking about the results.

Ms. COMBS. Well, we have had 87 criminal indictments.

Senator THOMAS. But you have got 144 out there still operating.

Ms. COMBS. It is a growing problem. As health insurance costs grow and as people are struggling to find affordable health insurance—

Senator THOMAS. What about licensing? They say they are not licensed.

Ms. COMBS. Well, the licensing is done by the States.

Senator THOMAS. Absolutely.

Ms. COMBS. And I do not mean to push that off on the States.

Senator THOMAS. But you have got this big, coordinated thing. Why do we not get that operating? I just am very impatient with what is going on here because there is an opportunity to do something and apparently we are not enforcing the things that we are capable of doing.

Ms. COMBS. I share your frustration. However, these people are not licensed because they are crooks. They do not want to be licensed. So, we have to find them and shut them down.

Senator THOMAS. You have got 600 people out there in your group, besides the States. It does not take too long to figure out who is advertising or who is putting it out there that is not licensed.

Ms. COMBS. Right. I think that is why we have worked hard on the education piece that Chairman Grassley mentioned. It is very important that we get the word out for people to help them avoid being taken advantage of, and we do think there needs to be a legislative alternative.

We are very committed to creating a new vehicle for small businesses, in particular, to get affordable health insurance so that they will not be subject to these scam artists. We do think there needs to be a change in the law.

Senator THOMAS. I am sorry, but I just cannot really understand what you are saying. You are supposed to be licensed, right?

Ms. COMBS. An insurance company. Yes.

Senator THOMAS. Yes. Is that not part of the answer?

Ms. COMBS. Absolutely.

Senator THOMAS. Then why is that so hard to enforce? I have been involved in this a little bit. It just does not seem to me like you are being realistic about the possibilities of doing something that is not too hard to understand.

Ms. COMBS. Well, again, our hook here is ERISA, so we are not the agency that enforces licensure.

Senator THOMAS. I understand that. But you say you are cooperating and working with the States.

Ms. COMBS. Yes. Absolutely.

Senator THOMAS. You are exactly right. When you get the association thing, you are going to have more of a problem than you have now. And if you cannot handle the problem you have now, how are you going to do that?

Ms. COMBS. Well, the certification is essentially a Federal license. If you do not have a certification, then an AHP can shut you down.

Senator THOMAS. Apparently licenses do not work.

Ms. COMBS. Well, we will be able to shut you down if we get a complaint. If we see an advertisement like the Senator had, we can shut them down.

Senator THOMAS. You are able to shut them down now.

Ms. COMBS. It takes longer.

Senator THOMAS. You are not, but you can work with the States.

Ms. COMBS. It is a frustrating situation. It is.

Senator THOMAS. I would say so.

Ms. COMBS. I do not mean to argue with you.

Senator THOMAS. I am not arguing either. I am just saying, you went through all the good things you are doing, but the results are not good.

Ms. COMBS. No. The results are not good. It is a tragedy.

Senator THOMAS. All right.

Senator KYL. Thank you. We have a problem in that there is activity on the floor which will probably preclude the Chairman from coming back to chair the hearing, and both Senator Thomas and I will have to leave in the not-too-distant future.

Therefore, what I am going to ask is for any other members to submit questions of this panel in writing. You will have an opportunity to respond to those questions in writing.

Unless you have anything else you would like to say at this point, what I would like to do is make sure that the third panel can come forward and make their presentations before we have to adjourn the hearing.

So, let me thank all three of you for being here. You may get some questions in writing. If so, we will look forward to your answers to those.

Thank you again for being here.

Ms. COMBS. Thank you very much.

Senator KYL. As this panel is leaving, I will call forward Fred Nepple, who is chair of the ERISA Working Group, National Association of Insurance from Austin, Texas; Jose Montemayor, the Commissioner of Insurance of the Texas Department of Insurance in Austin, Texas; and Mila Kofman, assistant research professor of the Health Policy Institute at Georgetown University here in Washington, DC.

We welcome all three of you. If we stick to the clock and the lights, we should be able to get all the testimony in before the hearing needs to be adjourned. So, I welcome all three of you.

Mr. Nepple, let us begin with you. We will just go down the line and conclude with Ms. Kofman, if that would be all right with you all.

Mr. NEPPLE. Thank you, Senator.

Senator KYL. Thank you.

STATEMENT OF FRED NEPPLE, CHAIR OF ERISA WORKING GROUP, NATIONAL ASSOCIATION OF INSURANCE, AND GENERAL COUNSEL, WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE

Mr. NEPPLE. Good morning, members of the committee. My name is Fred Nepple. I am general counsel for the Wisconsin office of the Commissioner of Insurance. I am also chair of the National Association of Insurance Commissioners ERISA Working Group.

It is in this capacity that I come before you today to discuss the NAIC's efforts to assist in the identification, elimination, and prosecution of unauthorized health plans.

Unauthorized health plans have had a destructive ripple effect impacting every aspect of the health care system, consumers, employers, providers, licensed health plans, and the States.

The number and scope of unauthorized health plans has spiked as health insurance premiums continue to rise at a double-digit pace. States and the Federal Government have been aggressive in their response, but the problem persists and we should do more.

All of the unauthorized health plans discussed in the GAO report, though they take on several different forms, have two factors in common: they offer a plan that claims to provide health benefits subject to ERISA, and they all claim to be exempt from State insurance regulation under ERISA.

The operators of unauthorized health plans rely on aggressive assertions of ERISA preemption to convince licensed agents and others to market their plans without alerting regulators.

When the State insurance regulators or the U.S. Department of Labor challenge operators, they commonly resist investigations and discovery with claims of ERISA preemption. They delay by claiming to have troubled information systems, poor claims records, inadequate accounting procedures, and litigation among themselves.

Operators of these plans are prepared to engage in extended litigation with regulators to further delay enforcement actions. This gains some additional time to collect premiums and dissipate assets while unfunded claims mount.

To address the problem of unauthorized health plans, the NAIC has implemented a number of initiatives. First, points of contact. The NAIC maintains a list of contacts in each State which is posted on its Web site.

This list identifies an individual in every State insurance department who is familiar with the issue of fraudulent plans and who can answer questions from the public and the insurance agent community.

Most insurance departments have this information on their Web site, as well as in their publications. This has proved to be an important tool for accelerating identification of suspicious plans.

Bulletins for consumer and agent education. The NAIC has developed bulletins for use by State insurance departments to draw attention to the issue of fraudulent plans and to provide guidance.

The consumer alert warns consumers about ERISA and union plan scams, has suggestions on how to be a smart shopper and to avoid fraudulent plans, and advises consumers to report to their State insurance department attempts to sell them fraudulent and often so-called union plans.

The agent alert reminds agents of their duty to inform State insurance departments any time they are approached by a suspicious entity.

Direct consumer education. The NAIC has budgeted almost \$300,000 to initiate a national media campaign on unauthorized insurance. This effort has just begun and will run through June, 2004.

This project includes media campaign development, media production, media relations, and Web site development. As a first step in the campaign, the NAIC printed a brochure, "Make Sure Before you Insure," which identifies signs of potential fraud and ways consumers can protect themselves. Needless to say, many State insurance departments have already conducted this type of media campaign.

Information for licensed insurers. The NAIC sent to all NAIC members in June, 2003 a model regulatory alert for stop-loss carriers and third party administrators. The alert reminds stop-loss carriers and third party administrators that, as part of their commitment to good business practices, they are obligated to review their internal controls and business practices to ensure they do not become unwitting accomplices of illegal health plans. Many State insurance departments have already utilized this bulletin.

Information for regulators. The NAIC distributes the ERISA handbook, which is currently being updated, which highlights for regulators the different types of unauthorized entities that seem to

be most prevalent and provides additional guidance on recognizing and shutting down fraudulent plans.

Information sharing among States and the Federal Government. The NAIC helps coordinate information-sharing among States and the Department of Labor on a continual basis.

Information is exchanged about suspect entities, individuals, third party administrators, agents, marketing firms, stop-loss carriers, re-insurers, and provider groups, essentially everyone involved in every aspect of what is often a complex, convoluted, and extensive scam. Over the years, States have become more focused on sharing information through these efforts.

The NAIC also engages in interstate coordination on specific investigations and is in the process of developing a model law that will stiffen and ease prosecution of unauthorized insurance.

In conclusion, unauthorized health plans are a growing problem that negatively impacts the public and the health care system. The NAIC works closely with the States and Federal Government to facilitate the prevention, identification, and elimination of unauthorized health plans.

I thank you for giving me the opportunity to speak today and I welcome the discussion that this hearing brings to us.

Senator KYL. Thank you, Mr. Nepple. I would welcome discussion too, but because of the time, I might announce in advance, you may get some questions in writing as well. I will have to leave in a moment. I will turn the chair over to Senator Thomas.

But Mr. Montemayor, it is yours. Thank you.

[The prepared statement of Mr. Nepple appears in the appendix.]

STATEMENT OF JOSE MONTEMAYOR, COMMISSIONER OF INSURANCE, TEXAS DEPARTMENT OF INSURANCE, AUSTIN, TX

Mr. MONTEMAYOR. Thank you, Mr. Chairman. Thank you, members. I really appreciate the opportunity to be here. I did submit a full statement for the record, but Senators, we need your help. We really do.

The view from the trenches is not so much that the problem is not that the States cannot stop the illegal ERISA plans from operating in their jurisdictions. The real problem is that the shield of a potential exemption from State regulation under ERISA currently creates the opportunity for scams to operate for a rather long period of time before they are recognized formally as illegal, and before formal action can be taken against them.

So, we do have the authority to shut these scams down and we do stop them, but we normally cannot do so until after a great deal of harm has been done.

In Texas, we have issued cease and desist orders against many of these plans. We have put one which is in Texas into a receivership. We have ordered millions of dollars in penalties against those who sold the plan. In 2003 alone, the last year, I issued over 100 orders against licensed insurance agents who sold unauthorized insurance, basically ordering three things.

I ordered them to pay, themselves, the unpaid claims, I issued fines to all of them, which are normally offset as they made claims payments, and in many cases I revoked their license.

The perpetrators, as it was pointed out to you, all have this common theme. They all sort of grabbed onto this ERISA preemption. They got great-looking documents that they put out to the public, and they are quite believable. They are very convincing and creative.

The examples abound. You heard about Employers Mutual. We put one in receivership ourselves called American Benefits Plan, and there is another plan called TRG. Clearly, most of the problem is, the people that wound up being victimized, as you learned, were the small employers who probably do not realize that most other employer plans or union plans are not available for sale to the general public.

Legitimately, you and I cannot buy into, say, the Coca-Cola health plan or the Teamsters health plan unless you are either an employee of Coke or you are a Teamster. That is the bridge, the leap forward that is being taken here that normally winds up with all of that harm. That is the common method.

Most of these people thought they were getting a great deal on health insurance. Many State departments of insurance were unaware that these plans were within their borders until all the complaints started flooding in. So, even then, it takes time to prove that the plans were operating as non-exempt MEWAs as opposed to exempt single employer or union plans.

I have got five solutions for you where we really need your help. Number one, we would request that the committee consider expanding powers of the Department of Labor to take action against illegal ERISA plans.

Currently, most of the focus appears to be on the breach of fiduciary duty or fraud in order to take civil or criminal action. This is, of course, a far cry from what we are able to do at the States.

At the States, we can merely show that the insurer is either insolvent or it is in hazardous financial condition and we can shut it down just on that. It is so much easier to demonstrate that a plan is broke as opposed to the breach of fiduciary duties. I think similar authority should be given to the DOL.

It is always particularly important because you have got to remember that ERISA health plans have no statutory requirements to maintain reserves to pay their claims, or that there is no guaranty fund protection should they actually fail.

The second recommendation is that DOL should also be given authority to issue preliminary cease and desist orders against plans that are in a financially hazardous condition. While this will not take care of the whole problem, it will at least stop them in their tracks from signing up new victims as they go on before we do eventually shut them down.

Third, there should be some specific criminal or civil penalties for falsely holding themselves out to be legitimate ERISA plans. I mean, you and I cannot hold ourselves out to be doctors, or a lawyer, or an accountant. You cannot hold yourself to be something you are not without incurring a penalty. There is no such penalty for holding yourself out to be a legitimate ERISA plan without actually being one.

Fourth, I recommend that ERISA plans be required to make up a preliminary filing. You heard this before. Disclosing, for example,

who will be operating the plan, who will be insured by this plan, and what back-up insurance do they have?

As mentioned previously, one of the factors that allows the quick growth of unauthorized plans is the inability of employers and consumers to check. For example, in Texas we have got a 1-800 line and we are online. You can always call our 1-800 line or get online and figure out who is legitimate, who is not, who is licensed.

In the case of ERISA plans, there is a gap of about 19 months. I think there is a Form 5500 that they can file after a year of operation, and then 7 months later they are required to make a filing.

There is a 19-month gap there where they can virtually operate under the radar and they can truthfully say to anybody that comes to shop, there is no place for you to call and check on us, you are just going to have to take my word on it.

The fifth recommendation, just briefly. The States must be given explicit authority to subpoena jurisdictional information. Typically what happens, we even get a lot of resistance, even saying, as we start investigating the purported ERISA plans to even determine if they are a MEWA or an illegal MEWA, is that they are protected from even having to give us some information because the Federal law preempts our authority even to ask. So, it is very, very problematic.

So, in conclusion, I appreciate you giving me this opportunity. It is a huge problem. We have taken a number of actions. There are some definite things that can be done in the here and now to improve on what we have got and get to the very issues we are asking about that cause us an enormous amount of frustration. Thank you, Senator.

Senator THOMAS. Thank you.

[The prepared statement of Mr. Montemayor appears in the appendix.]

Senator THOMAS. Ms. Kofman?

STATEMENT OF MILA KOFMAN, ASSISTANT RESEARCH PROFESSOR, HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Ms. KOFMAN. Thank you very much. As you can tell from my voice, I have laryngitis, so my statement will be pretty brief.

Senator THOMAS. Do you have insurance? [Laughter.]

Ms. KOFMAN. Luckily, I am married to a Federal employee. Thank you. [Laughter.]

My name is Mila Kofman and I am an assistant research professor at Georgetown University's Health Policy Institute. My expertise is with private health insurance and my most recent research has focused on health insurance scams.

Thank you for investigating this serious problem. It is an honor for me to be here to share with you findings of my research. It is also terrific that the GAO findings are completely consistent with my research findings, which I reported on last year.

I would respectfully request that my written statement and the Commonwealth report summarizing the research findings be made part of the record.

Senator THOMAS. It shall be.

Ms. KOFMAN. Thank you.

[The prepared statement of Ms. Kofman appears in the appendix.]

Ms. KOFMAN. An influx in phony health plans is a symptom of a larger problem, which is the lack of affordable health insurance, desperate employers and people looking for alternatives to keep themselves and their families insured.

You heard from two victims this morning. I can give you lots and lots of other victims. One person decided to forego cancer treatment when he learned that his health coverage was phony. He did not want to burden his family to be responsible for his additional bills for cancer treatment. He is now dead.

I have another person I spoke to who now has long-lasting, life-long physical conditions. She cannot see out of one of her eyes. So, the victims you heard from this morning are the lucky ones, the survivors. Many are not going to survive the cycle of scams.

Many victims, I know, are still uninsured as a result. They do not have access to employer-based health insurance and, because of existing medical conditions, they cannot find new insurance in the individual market. The ones that do are surcharged or their existing conditions are not covered. So, it is an ongoing problem even after the scam is shut down.

I will not go into the details of the facade of legitimacy that these scams operate under. You heard from the GAO and some of the other folks here.

I do want to talk briefly about the operators of the scams. The scams I looked at, they are all repeat offenders. They have done it before. They know how to do it, and that is how they can get away with it.

You heard from the GAO about one of the principals of Employers Mutual. He was shut down by the California Insurance Department in 1999, then was shut down again in 2000 for running a similar scam. That is the same year he started Employers Mutual.

They sometimes change their names, they sometimes move to new States, other times they do not even bother. They just change the name of the scam and stay in the same office selling phony health insurance again and again.

Where does the money go? You heard Employers Mutual collected over \$16 million in premiums and only paid a small portion of that in claims and legitimate expenses. Well, they run pretty slim operations. One company had a P.O. box and no employees and was taking in millions of dollars. Another company had a small office in a shopping center, again, a national scam, taking in millions of dollars.

They live the lifestyle of the rich and not-so-famous. They have country club memberships. They take worldwide vacations. They buy expensive houses. One operator bought a castle in Ireland. They rent expensive properties behind gated communities. They pay off expensive mortgages. They buy expensive cars. That is where the premiums go.

The ones who do not spend the money hide the assets offshore in offshore bank accounts. They are very good at that. They move assets around very quickly. In one case, the Federal District Court judge ordered assets to be frozen. In response to that, the operators moved assets around into new banks and new bank accounts.

Well, this Federal judge was pretty smart. The next order seizing assets and freezing them was done under seal. In fact, he issued subsequent orders and they are still under seal, which means that the operators do not know that the assets have been frozen.

I agree with you, Senator Thomas, government response is not as good as it should be. Although there is a lot of efforts by States and some by the Department of Labor to address this problem, unfortunately government institutions—Federal Government institutions, that is—are not doing what they are supposed to do to protect the victims.

The biggest problem is that operators of these scams are still out there and they can do the same thing again and again. They have not been indicted. These people are still not in jail.

Civil actions do not stop them. You need more Federal actions and you need faster actions by the Federal Department of Labor. It is unacceptable that it takes 2 years to go to Federal court to shut an entity down.

The same entity that States shut down 2 years ago, the Department of Labor just recently went to Federal court to shut down. By then, it is too late. All the assets have been hidden or spent. That does not help victims. Thank you. My time is up. I am happy to take questions.

Senator THOMAS. Well, thank you. Thank you all very much. I think you have shed a lot of light on this. Ms. Kofman, if the States see someone that looks like they are operating illegally, but they say they are working under ERISA, can they not get a response as to whether they are or are not right away?

Ms. KOFMAN. It takes time. It is just a delay tactic. These operators know that, as long as they can stay out there and stay out of State court, they can hide assets and spend the money. It does take time to get a determination that these things are not ERISA.

In many instances, these operators remove State cases to Federal court to delay State action. One State spent half a million dollars litigating the ERISA question.

Senator THOMAS. Mr. Commissioner, I get the impression that that is kind of what you hear when someone is doing something. ERISA does not list them, does not know?

Mr. MONTEMAYOR. There is that gap, that long gap of time that they are not required to register.

Senator THOMAS. Just to identify whether they are in ERISA or not?

Mr. MONTEMAYOR. Right. They are self-anointed, originally. They are not required to file anything with anybody until their first filing, which I think is a 5500, or something like that, which is due at the end of their first year of their operations.

That is not due in for another 7 months after that, so you can almost go about 19 months completely legitimately as a declared ERISA plan. I mean, we have packed a lot of convenience into ERISA to facilitate groups coming together and getting that coverage, and I think that they have just been using that. I think if they register initially right off the bat before they sign up the first person, it would help tremendously.

Senator THOMAS. I see. This is part of the problem. This is one of the difficulties for the States to really function with some of them. Is that correct?

Mr. NEPPLE. That is correct, Senator. In fact, right now, I opened an investigation on Monday on a union plan that we learned was sold to several people in the State of Wisconsin. I brought in two Wisconsin agents and questioned them on Monday. I expect I am going to issue a demand for records from the union when I get back.

I expect the unions can claim that it is exempt under ERISA and refuse to produce the records, which puts me in the position of proving the negative as to whether they, in fact, are a collectively bargained plan established pursuant to a collective bargaining agreement.

I will do that. It will take time. Meanwhile, fortunately, only five people in the State of Wisconsin who have been covered will be moved to our high-risk plan or other coverage.

Senator THOMAS. That is interesting. They talked about the cooperative activity. Is there a relationship, pretty close, between your State operations and DOL?

Mr. MONTEMAYOR. No question about it. We talk to those folks every single week. In my department, I have got a coordinator just for the Texas Department of Insurance, assigned full-time to nothing but that, and about 20 people part-time supporting him on the civil side.

On the criminal side, I have got a full-fledged criminal team on my fraud division after this very same thing, putting cases together to give them to a prosecutor and prosecuting them. In our efforts, we always tie in with the DOL folks in the Dallas office and coordinate that.

Senator THOMAS. Well, I really appreciate your listing the things you think for remedies. That is really where we are. We all know we have got a problem. The first panel laid that out pretty well.

But the solutions. Do you basically agree with the five things he mentioned?

Mr. NEPPLE. I think they are very worthwhile areas that we should work on, carefully, Senator.

Senator THOMAS. Ms. Kofman, do you have any suggestions other than that in terms of resolving the problem?

Ms. KOFMAN. Yes. I think there is a perception out there that the Justice Department is not prosecuting these cases, and I think there is good reason for that perception, because we have not seen any criminal indictments on these current operators. So one of the suggestions I have for you is to ask the Justice Department why they are not going forward with these cases.

In one Federal case, the District Court judge had to order the U.S. Attorney's Office to open a criminal investigation based on evidence that he saw in a private civil case where there was evidence of money laundering, fraud, health care fraud, wire fraud, all sorts of RICO violations. A Federal judge had to order the Justice Department to investigate. That is a big problem.

Senator THOMAS. Yes. Well, this seems like this is different than someone who unlawfully goes in and does a couple of things and

disappears. These are people that are out there, and so on. It seems like there ought to be some remedies, and I appreciate that.

Well, thank you so much. The record will stay open, unusually, for 3 weeks in case someone wants to ask you some more questions.

But it is my understanding that the Chairman has a plan to look at this issue further and ensure that the responsible agencies have the tools to do the jobs that are there.

So, we thank you very much for being here and look forward to working with you in finding some remedies for the things that are wrong. Thank you very much.

The committee is adjourned.

[Whereupon, at 11:09 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

GAO

United States General Accounting Office

Testimony
Before the Committee on Finance, U.S.
Senate

For Release on Delivery
Expected at 9:30 a.m. EST
Wednesday, March 3, 2004

PRIVATE HEALTH INSURANCE

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

Statement of

Kathryn G. Allen, Director
Health Care—Medicaid and Private Health Insurance Issues

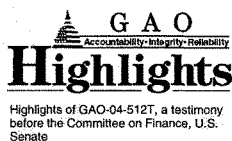
Robert J. Cramer, Managing Director
Office of Special Investigations



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GAO-04-512T



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/gettrpt?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.

March 3, 2004

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.

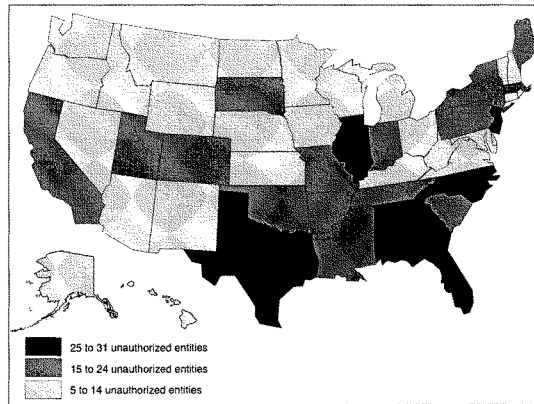
states' authority to regulate insurers and insurance policies). Therefore, under ERISA, self-funded employer group health plans generally are not subject to the state oversight that applies to insurance companies and health insurance policies. The federal and state governments coordinate their regulation 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, EBBSA 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: EBBSA.

^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, EBBSA 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.

*All 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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United States General Accounting Office

Report to Congressional Requesters

February 2004

PRIVATE HEALTH INSURANCE

Employers and
Individuals Are
Vulnerable to
Unauthorized or
Bogus Entities Selling
Coverage



G A O

Accountability • Integrity • Reliability

GAO-04-312



Why GAO Did This Study

Health insurance premiums have increased at double-digit rates over the past few years. While searching for affordable options, some employers and individuals have purchased coverage from certain entities that are not authorized by state insurance departments to sell this coverage. Such unauthorized entities—also sometimes referred to as bogus entities or scams—may collect premiums and not pay some or all of the legitimate medical claims filed by policyholders. GAO was asked to identify the number of these entities that operated from 2000 through 2002, the number of employers and policyholders covered, the amount of unpaid claims, and the methods state and federal governments employed to identify such entities and to stop and prevent them from operating.

GAO analyzed information on these entities obtained from the Department of Labor (DOL) and from a survey of the 50 states and the District of Columbia. GAO also interviewed officials at DOL headquarters, at three regional offices, and at state insurance departments responsible for investigating these entities in four states—Colorado, Florida, Georgia, and Texas.

www.gao.gov/cgi-bin/gettrpt?GAO-04-312.

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.

February 2004

PRIVATE HEALTH INSURANCE

Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage

What GAO Found

DOL and the states identified 144 unique entities not authorized to sell health benefits coverage from 2000 through 2002. The number of entities newly identified increased each year, almost doubling from 31 in 2000 to 60 in 2002. Many of these entities targeted employers and policyholders in multiple states, and, of the seven states with 25 or more entities, five were located in the South.

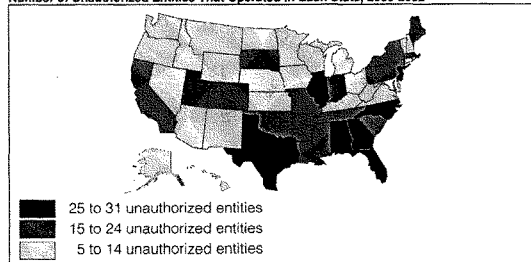
DOL and the states reported that the 144 unique entities

- sold coverage to at least 15,000 employers, including many small employers;
- covered more than 200,000 policyholders; and
- 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.

States and DOL often identified these entities based on consumer complaints. DOL often relied on states to stop these entities within their borders while DOL focused its investigations on larger entities operating in multiple states and, in three cases, obtained court orders to stop these entities nationwide. Most of the states' prevention activities were geared to increasing public awareness and notifying the agents who sold this coverage, while DOL focused its efforts on alerting employer groups and small employers.

In commenting on a draft of this report, DOL, the National Association of Insurance Commissioners, Florida, and Texas highlighted their efforts to increase public awareness, coordinate investigations, and take enforcement actions regarding these entities.

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.

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Abbreviations

DOL	Department of Labor
EBSA	Employee Benefits Security Administration
ERISA	Employee Retirement Income Security Act of 1974
MEWA	multiple employer welfare arrangement
NAIC	National Association of Insurance Commissioners
TRO	temporary restraining order

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United States General Accounting Office
Washington, D.C. 20548

February 27, 2004

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

The Honorable Olympia J. Snowe
Chair
Committee on Small Business and Entrepreneurship
United States Senate

The Honorable Christopher S. Bond
United States Senate

As health insurance premiums in the private health insurance market increased at double-digit rates over the past several years, some employers, particularly small employers with fewer than 50 employees, have faced difficulty in obtaining affordable coverage. Small employers cited cost as the major obstacle they faced in providing health care coverage to their employees. As they looked for affordable options, some employers and individuals have purchased health care coverage from certain entities that have not complied with state insurance law or with federal and state requirements for coverage provided to multiple employers. These unauthorized entities—also sometimes referred to as bogus entities or as scams or fraudulent insurers—may price their products below market rates but may not meet financial and benefit protections typically associated with health insurance products that are authorized, licensed, and regulated by the states. These entities collect premiums from individuals or employers but may not pay some or all legitimate claims filed by the policyholders or those covered by the policies.

According to several media reports during the past few years, employers and individuals may increasingly be targeted by entities not authorized to sell health coverage. These entities were also particularly problematic in two earlier periods during the past 30 years—the mid-1970s to early 1980s and the late 1980s to early 1990s. When these entities do not pay legitimate claims, different parties can be harmed, including individual policyholders who may be held responsible for their own medical bills, which can mean owing thousands of dollars. Providers are also at increased risk of not being paid for services already rendered. Concerned about this situation, you asked us to determine the prevalence of these entities and their impact

on employers, especially small employers, and policyholders. Specifically, we examined

1. the number and types of unauthorized entities selling health benefits that federal and state governments identified from 2000 through 2002;
2. the number of employers, including small employers, and policyholders covered by these entities, the amount of associated unpaid claims, and the amounts recovered from these entities; and
3. the methods federal and state governments have employed to identify such entities and to stop or prevent them from continuing to operate.

To identify the number of unauthorized entities from 2000 through 2002, we analyzed information we obtained from the federal and state governments. We obtained federal-level data from the Department of Labor's (DOL) Employee Benefits Security Administration (EBSA). EBSA conducts civil and criminal investigations of employer-based health benefits plans, which include entities that did not meet federal and state requirements.¹ To obtain state-level data, we surveyed and received responses from officials at departments of insurance or equivalent offices in all 50 states and the District of Columbia.² Because multiple states and EBSA provided information on some of the same entities, we relied on several different sources, along with our judgment regarding similar entity names, to consolidate the federal and state information and identify the number of unique entities. Some states did not report on entities that they were still investigating. Therefore, the number we report likely represents the minimum number of unauthorized entities operating from 2000 through 2002. We also asked states to provide information on a related type of problematic arrangement—discount arrangements that may be misrepresented as insurance. To determine the types of entities, the number of employers and policyholders covered, the amount of unpaid claims, and the amounts recovered from these entities, we analyzed the data EBSA and the states reported to us. DOL and the states could not

¹EBSA regulates employer-based pension and welfare benefits plans, which include employer-based health benefits. Specifically, the Office of Enforcement in EBSA, among other activities, conducts investigations through its regional offices to find and correct violations of federal law that relate to employer-based pension and welfare benefits plans.

²Throughout this report, 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.

provide comparable data on how many people in total were affected by these entities. Therefore, we combined the data that states reported on the number of policyholders with the data that DOL reported on the number of participants and refer to them throughout this report as policyholders. Most states and DOL reported to us from March through June 2003. The data we report likely underestimate the total numbers of employers and policyholders covered as well as the amounts of unpaid claims and amounts recovered to pay for these claims because neither EBSA nor states could provide this information for some entities. To identify the methods that the federal and state governments employed to identify these entities and to stop and prevent them from continuing to operate, we analyzed information obtained from DOL, our state survey, state insurance departments' Web sites, and other research, as well as through interviews with federal and state officials; officials of several associations, including the National Association of Insurance Commissioners (NAIC); and experts on these entities. We interviewed federal officials at DOL headquarters and at three EBSA regional offices—Atlanta, Dallas, and San Francisco—and state officials at insurance departments in four states—Colorado, Florida, Georgia, and Texas. We selected the EBSA regional offices and states based on recommendations from federal and state officials and others we contacted who suggested that these regions and states had been affected by relatively more of these entities. We also interviewed association officials and several experts who had published research addressing unauthorized or fraudulent entities.³ We also reviewed relevant literature. While we obtained information on the methods that federal and state governments employed to identify these entities and to stop and prevent them from operating, we did not evaluate the effectiveness of these methods.

Appendix I provides more detailed information on our methodology. We performed our work from January 2003 through February 2004 in accordance with generally accepted government auditing standards.

Results in Brief

DOL and the states identified 144 unique entities not authorized to sell health benefits coverage from 2000 through 2002. Over these 3 years, the number of such entities newly identified each year almost doubled from 31

³See Mila Kofman, Kevin Lucia, and Eliza Bangit, "Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed," *The Commonwealth Fund* (2003), for a recent review of related issues.

in 2000 to 60 in 2002. Many of these entities operated in more than one state and some operated under more than one name or with more than one affiliated entity. These entities most often marketed their products in southern states. For example, of the seven states that had 25 or more entities, five were located in the South. 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. The most common characterizations were as (1) associations, in which these entities either sold their products through associations they created or through established associations of employers or individuals, and (2) professional employer organizations, which contracted with employers to administer employee benefits and perform other administrative services for contract employees. Relatedly, 14 states also reported that at least some discount plans, in which the purchaser receives a discount from the full cost of certain health care services from participating providers, were misrepresented as insurance, and 8 of these states identified small employers as a particular target of these misrepresented discount plans.

DOL and the states reported that the 144 unauthorized entities covered at least 15,000 employers and more than 200,000 policyholders from 2000 through 2002. 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 the states reported that the 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. Ten of the 144 entities covered about 64 percent of the affected employers and about 56 percent of the policyholders, and accounted for 46 percent of the unpaid claims.

States and DOL employed similar methods to identify these unauthorized entities and to prevent them from operating, but used different methods to stop their activities. To identify these entities, state insurance departments and DOL often relied on consumer complaints. The primary action states took to stop the entities' activities was to issue cease and desist orders. State insurance departments issued these 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. DOL relied on the states to issue cease and desist orders while it conducted investigations to obtain evidence that it could use to stop these entities in multiple states through the federal courts. DOL obtained court orders against three entities from

2000 through 2002. Each of these three entities affected consumers in more than 40 states; combined, the three entities affected an estimated 25,000 policyholders and accounted for about \$39 million in unpaid claims. Because most of the DOL investigations were ongoing as of August 2003, further actions remain possible. 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.

We provided a draft of this report to DOL, NAIC, and the four state insurance departments whose officials we interviewed. DOL, NAIC, Florida, and Texas provided written comments. DOL identified initiatives it has taken to improve coordination with states and law enforcement agencies, and also summarized its criminal enforcement actions. NAIC, Florida, and Texas commented that the report illustrated the extent to which unauthorized entities have harmed individuals and small employers, and they provided additional information on how the federal and state governments have coordinated and collaborated in their efforts and noted other public awareness and criminal enforcement efforts they have undertaken.

Background

Generally, employers can provide health coverage in two ways. They can purchase coverage from health insurers, such as local Blue Cross and Blue Shield plans; other private insurance carriers; or managed care plans, such as health maintenance organizations. Alternatively, they can self-fund their plans—that is, they assume the risk associated with paying directly for at least some of their employees' health care costs—and typically contract with an insurer or other company to administer benefits and process claims. When small employers offer health coverage, most tend to purchase insurance rather than self-fund. Only about 12 percent of the establishments at firms with fewer than 50 employees that offered coverage in 2001 had a self-funded plan,⁴ compared with about 58 percent of the establishments at firms with 50 or more employees. Moreover, about

⁴An establishment is a workplace or physical location where business is conducted or operations are performed. A firm includes a company's headquarters and all divisions, subsidiaries, and branches and may consist of one or more establishments under common ownership or control.

76 percent of the establishments at the largest firms—those with 500 or more employees—offered at least one self-funded plan.⁵

States regulate the insurance products that many employers purchase.⁶ 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 agents who sell these 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 consumer protections such as those relating to appeals of denied claims.⁷

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).⁸ 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).⁹ DOL is primarily responsible for administering Title I of ERISA. Among other requirements, ERISA establishes plan reporting and disclosure requirements and sets

⁵Agency for Healthcare Research and Quality, *2001 Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics* (Rockville, Md.: 2003), <http://www.meps.ahrq.gov/mepsdata/ic/2001/index100.htm> (downloaded Sept. 3, 2003).

⁶The McCarran-Ferguson Act, March 9, 1945, Ch. 20, § 2, 59 Stat. 33, 34, establishes the primary authority of the states to regulate the business of insurance, unless federal law provides otherwise.

⁷State 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.

⁸Pub. L. No. 93-406, 88 Stat. 829.

⁹MEWAs, which can be insured or self-funded, 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 the result of collective bargaining agreements, or plans established or maintained by a rural electric cooperative or a rural telephone cooperative association.

fiduciary standards for the persons who manage and administer the plans.¹⁰ 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 is through an insurance policy or a self-funded plan. In addition, ERISA generally preempts states from directly regulating employer-sponsored health plans (while maintaining states' ability 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 the insurance companies and health insurance policies. Prior to 1983, a number of states attempted to subject MEWAs to state insurance law requirements, but MEWA sponsors often claimed ERISA-plan status and federal preemption. A 1983 amendment to ERISA made it clear that health and welfare benefits provided through MEWAs were subject to both federal and state oversight.¹¹ The federal and state governments now coordinate the 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

DOL and the states identified 144 unauthorized entities from 2000 through 2002. Many of these 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 operated most often in southern states. The number of such entities newly identified each year grew from 31 in 2000 to 60 in 2002. About 80 percent of these entities characterized themselves as one of four arrangements or some combination of the four. In addition, some states reported that discount plans misrepresented their products as health insurance.

¹⁰Under 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.

¹¹Pub. L. No. 97-473, § 302, 96 Stat. 2605, 2612.

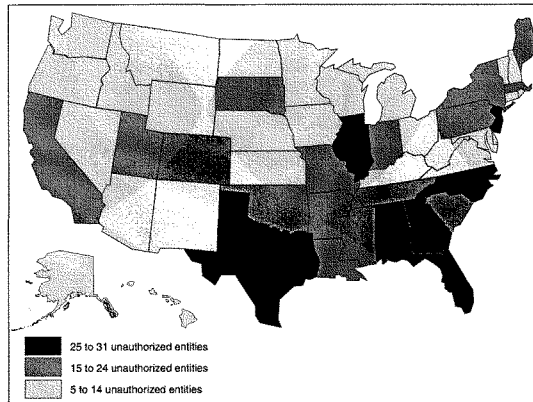
Unauthorized Entities Were
Concentrated in the South
and the Number Identified
Grew Rapidly from 2000
through 2002

DOL and 42 states¹² identified 144 unique unauthorized entities from 2000 through 2002. Many of these entities marketed their products in more than one state, and some operated under more than one name or with more than one affiliated entity. This likely represents the minimum number of unauthorized entities operating from 2000 through 2002 because some states did not report on entities that they were still investigating. Of the 144 unique entities, 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.

Unauthorized entities identified by DOL and the states from 2000 through 2002 operated in every state, ranging from 5 entities in Delaware and Vermont to 31 in Texas. (See fig. 1.) 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. Unauthorized 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, there were 30 in Florida, 29 each in Illinois and North Carolina, 28 in New Jersey, 27 in Alabama, and 25 in Georgia.

¹²Nine of the 51 states responding to our survey did not report identifying any unauthorized entities from 2000 through 2002. However, entities identified by DOL through its multistate investigations operated in these states.

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

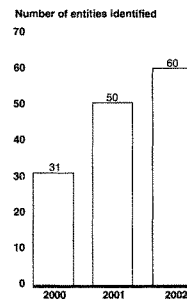


Source: GAO analysis of DOL and state data.

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.

The number of unauthorized entities newly identified by DOL and the states each year almost doubled from 2000 through 2002. The number increased significantly from 2000 to 2001, and it continued to increase from 2001 to 2002. (See fig. 2.)

Figure 2: Number of Newly Identified Unique Unauthorized Entities, 2000-2002



Source: GAO analysis of DOL and state data.

Note: The total excludes three unauthorized entities because one state did not provide the year it identified them.

Several DOL officials, state officials, and experts pointed to rapidly increasing health care costs and the weak economy as two factors contributing to the recent growth in the number of identified unauthorized entities. They suggested that the pressure of rising premiums and decreasing revenues may have increased employers' demand for more affordable employee health benefits, particularly among small employers, and thereby created an environment where unauthorized entities could spread. From 2000 through 2002, firms with fewer than 50 workers experienced an average annual increase in their workers' health benefits of about 13.3 percent, whereas firms with 50 or more workers experienced an average annual increase of 10.9 percent.¹⁹ The United States economy also showed signs of weakness in the third quarter of 2000 when it experienced growth of 0.6 percent, and suffered a recession in 2001. The economy's subsequent recovery in 2002 was marked by moderate economic growth but rising unemployment. Negative or weak growth in employers' revenues,

¹⁹We based our calculation on data reported in Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2000 Annual Survey*, *Employer Health Benefits 2001 Annual Survey*, and *Employer Health Benefits 2002 Annual Survey* (Menlo Park, Calif. and Chicago: 2000, 2001, and 2002).

compounded by rising premiums particularly for small employers, created an attractive environment for unauthorized entities, as small employers and others sought cheaper employee health benefit options.

**Entities Characterized
Themselves as One of
Several Common Types of
Arrangements**

About 80 percent of the unauthorized entities identified by DOL and the states characterized themselves as associations, professional employer organizations, unions, single-employer ERISA plans, or some combination of these 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. Under ERISA, both states and the federal government regulate MEWAs, with states focusing on regulating the fiscal soundness of MEWAs and licensing their operators and DOL enforcing ERISA's requirements.

Specifically, as shown in table 1, 27 percent of the entities identified by the states and DOL characterized themselves as associations in which employers or individuals bought health benefits through existing associations, or through newly created associations established by the unauthorized entities. For example, Employers Mutual, LLC, an entity that operated in 2001, sold coverage through an existing association. Employers Mutual also created 16 associations as vehicles for selling its products. (See app. II for a more detailed discussion of Employers Mutual, LLC.) In addition, 26 percent of the entities identified were 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. Another 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. Eight 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 that 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.

Table 1: Types of Unauthorized Entities Identified by DOL and States, 2000-2002

Entity type	Number	Percentage
Association	39	27
Professional employer organization	37	26
Union	13	9
Single-employer ERISA	11	8
Combination ^a	14	10
Other ^b /unknown	30	21
Total	144	100^c

Source: GAO survey of states and DOL data.

^a"Combination" is any combination of two or more unauthorized entity types, for example, "association" and "professional employer organization."

^bSome examples of "other" include individual and small group insurance and third-party administrators for single-employer ERISA plans that states identified as unauthorized.

^cPercentages do not add to 100 percent due to rounding.

Some States Reported That Discount Plans Misrepresented Themselves as Health Insurance

Some discount plans, in which the purchaser receives a discount from the full cost of certain health care services from participating providers, were misrepresented as insurance. 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, and 14 states reported that some discount plans were inappropriately marketed as health insurance products in some manner. Among these 14 states, 8 reported that the inappropriately marketed discount plans targeted small employers. While discount plans are not problematic as long as purchasers clearly understand the plans, these 14 states reported that some discount plans were marketed as health insurance with terms or phrases such as "medical plan," "health benefits," or "pre-existing conditions immediately accepted." (See app. III for more information on discount plans.)

Unauthorized Entities Covered Thousands of Employers and Policyholders, Leaving Hundreds of Millions of Dollars in Unpaid Claims

At least 15,000 employers, including many small employers, purchased coverage from unauthorized entities, affecting more than 200,000 policyholders from 2000 through 2002. The states reported that more than half of the organizations 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, and only about 21 percent of these claims, about \$52 million, had been recovered on behalf of those covered by these entities. Ten of the 144 entities covered the majority of employers and policyholders and accounted for almost one half of unpaid claims.

Based on our survey of states and information from DOL, we estimate that unauthorized entities sold coverage to at least 15,158 employers. The states reported that more than half of the entities they identified targeted their health benefits to small employers.¹⁴ Furthermore, unauthorized entities covered at least 201,949 policyholders across the United States from 2000 through 2002. The number of individuals covered by unauthorized entities was even greater than the number of policyholders covered because a policyholder could be an employer or an individual with dependents. Therefore, any one policyholder could represent more than one individual.

At the time of our 2003 survey, DOL and state officials reported that unauthorized 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.¹⁵ These recoveries could include assets seized from unauthorized entities that had been shut down or frozen from other uses. Licensed insurance agents have also settled unpaid claims voluntarily or through state or court action. However, the amount of unpaid claims recovered could grow over time as ongoing investigations are resolved. Investigations of unauthorized entities are complex and require

¹⁴DOL could not quantify the share of employers purchasing from unauthorized entities that were small employers.

¹⁵Most states and DOL reported to us from March through June 2003.

significant resources and time to thoroughly probe because operators often maintain poor records and hide assets, sometimes offshore. DOL and state officials explained that by the time they become aware of an unauthorized entity—often when medical claims are not being paid—the entity is sometimes on the verge of bankruptcy and may have few remaining assets with which to pay claims. Thus, while some additional assets may be recovered from the entities identified from 2000 through 2002, it is likely that many of the assets will remain unrecovered.

Ten large entities identified by DOL and the states covered a majority of employers and policyholders and accounted for nearly half of unpaid claims. Of the 144 unique entities, 10 covered about 64 percent of the employers and about 56 percent of the policyholders. They also accounted for 46 percent of the unpaid claims. (See table 2.) Some of these large entities grew rapidly and existed for short periods. For example, from January through October 2001, Employers Mutual enrolled over 22,000 policyholders; covered about 1,100 employers; and amassed over \$24 million in unpaid claims, none of which have been paid.

Table 2: Impact of 10 Large Unauthorized Entities, 2000-2002

	Employers		Policyholders		Unpaid claims*	
	Number	Percentage	Number	Percentage	Amount	Percentage
Ten entities	9,676	63.8	112,429	55.7	\$116.0	46.0
All others	5,482	36.2	89,520	44.3	\$136.2	54.0
Total	15,158	100.0	201,949	100.0	\$252.2	100.0

Source: GAO analysis of DOL and state data.

Note: Neither DOL nor states were able to report the number of employers or policyholders or the amount of unpaid claims for some unauthorized entities.

*DOL data were as of June 2003 and most state data were reported from March through June 2003.

**States and DOL
Employed Similar
Methods to Identify
Unauthorized Entities
and Prevent Them
from Operating, but
Different Methods to
Stop Them**

States and DOL took generally similar actions to identify unauthorized entities and prevent them from operating, but they followed different approaches to stop these entities' activities. States and DOL often relied on the same method to learn of the entities' operations—through consumer complaints. In addition, NAIC played an important role in the identification process by helping to coordinate and distribute state and federal information on these entities. To stop the operations of these entities, state agencies issued cease and desist orders, while DOL took action through the federal courts. Both state and DOL officials said that increased public awareness was important to help prevent such entities from continuing to operate.

**States and DOL Relied on
Similar Methods to Identify
Unauthorized Entities**

States and DOL identified unauthorized entities through similar methods. While states reported that most often they became aware of the entities' operations from consumers' complaints, they also received complaints about these entities from several other sources, such as agents, employers, and providers. DOL also often learned of these entities through consumer complaints. In addition to information obtained through NAIC, state insurance departments and EBSA regional offices relied on each other to learn of the entities' activities.

**States Identified Entities
Primarily through Consumer
Complaints, as Well as through
Other Methods**

States identified entities operating within their borders through several different methods, including complaints from consumers, information coordinated by NAIC, information from DOL, and a combination of these and other methods. States most often identified unauthorized entities operating within their borders through consumer complaints. (See table 3.)

Table 3: Methods States Used to Identify Unauthorized Entities, 2000-2002

Identification method	Number of entities identified through the method alone or combined with other methods
Consumer complaints	164
NAIC information	98
DOL information	49
Insurance agent complaints	46
Other*	45
Employer complaints	28
Provider complaints	16

Source: GAO analysis of state survey responses.

Note: In total, states reported 288 unauthorized entities operating within their borders. We determined that, after accounting for duplicate identifications among states and DOL, 144 unique entities operated from 2000 through 2002.

*"Other" includes identification through an insurance company, contact with another state, and other methods.

In addition to consumer complaints, states relied on other sources to help identify the unauthorized entities, with NAIC being the second most frequent source of information. In December 2000, NAIC started to share information from state and federal investigators on these entities with all states and DOL. In about 71 percent of the 98 cases where states reported using the NAIC information to identify unauthorized entities, they also reported using information from one or more other sources—most often consumer complaints. In addition, DOL and insurance agents, either alone or in combination with other identification methods, helped states identify the entities. For example, DOL submitted quarterly reports to NAIC that identified all open civil investigations, the individuals 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.

DOL Identified Entities through Consumer and State Contacts

Federal investigators also often identified unauthorized entities through consumers' complaints. According to EBSA officials, consumers call DOL's customer service lines when they have complaints or questions and speak with benefits advisers about the employer-based health benefits plans in which they are enrolled. Regional directors in EBSA's Atlanta, Dallas, and San Francisco offices said they open investigations when benefit advisers cannot resolve the complaints.

	Federal investigators also relied on states to help identify unauthorized entities. An EBSA headquarters official told us that states usually alerted federal investigators to the entities operating within their regions. The directors of the three EBSA regional offices we interviewed said they had received referrals from state insurance department officials within their regions.
State Insurance Departments Issued Cease and Desist Orders to Stop Unauthorized Entities, While DOL Took Action through the Federal Courts	States generally issued cease and desist orders to stop the activities of unauthorized entities. In contrast, DOL obtained injunctive relief through the federal courts by obtaining temporary restraining orders (TRO) or preliminary or permanent injunctions to stop unauthorized entities' activities. 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 courts.
States Issued Cease and Desist Orders to Stop Activities of Unauthorized Entities	After identifying the unauthorized entities, the primary mechanism states used to stop them from continuing to operate was the issuance of cease and desist orders. Generally, these cease and desist orders told the operators of the entities, and affiliated parties, to stop marketing and selling health insurance in that state and in some cases explicitly established their continuing responsibility for the payment of claims and other obligations previously incurred. About 71 percent of the states (30 of 42 states) that reported unauthorized entities operating within their borders from 2000 through 2002 issued at least one cease and desist order to stop an entity's activities during that time. The number of cease and desist orders issued by each of the 30 states ranged from 1 to 11, averaging about 4 per state. Alabama, Illinois, and Texas, three states in which more than 25 unauthorized entities operated, reported issuing the most cease and desist orders. A cease and desist order applies to activities only within the state that issues the order. Therefore, in several cases, more than one state issued a cease and desist order against the same entity. For example, 14 states reported that they each issued a cease and desist order to stop Employers Mutual's operations within their borders. States issued a total of 108 cease and desist orders that affected 41 of the 144 unique entities nationwide. About 58 percent of policyholders and nearly half of unpaid claims were associated with these 41 entities. State insurance departments generally had the authority to issue cease and desist orders. The insurance department officials we interviewed in Colorado, Florida, Georgia, and Texas said that the insurance

commissioner or holder of an equivalent position could issue a cease and desist order when there was enough evidence to support the need. From 2000 through 2002, these four states told us that they issued 25 cease and desist orders against about 58 percent of the entities they identified. According to these insurance department officials, the time needed to obtain a cease and desist order varied depending on such factors as the complexity of the entity to be stopped, a state's resources for conducting investigations, and whether others had already conducted investigations.

States typically shared information on the cease and desist orders they issued with NAIC. NAIC has developed a system to capture information on various state insurance regulatory actions, including cease and desist orders issued. States have access to the information reported through this system.

States took other actions against the 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.¹⁶ States also reported that they took actions against the entity operators in 25 instances and filed cases in court in 14 instances.

DOL Stopped Unauthorized Entities' Activities through Federal Courts

DOL can take enforcement action to stop an unauthorized entity's activities through the federal courts—that is, by seeking injunctive relief and, in some cases, pursuing civil and criminal penalties. An 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 TROs, 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

¹⁶The four states whose officials we interviewed had laws that specified the consequences that unauthorized entities, or the agents and others who represented them, would face. For example, Florida enacted a statute to increase the penalty for certain agents and others representing unauthorized insurers from a second-degree misdemeanor to a third-degree felony, punishable by up to 5 years in prison and up to a \$5,000 fine, effective October 1, 2002. Fla. Stat. ch. 626.902(1)(a), (b) (2003) (as amended by 2002 Laws, ch. 2002-206). An existing Florida statute already required certain persons representing unauthorized insurers in the state to be held financially responsible for unpaid claims. Fla. Stat. ch. 626.901(2) (2003). Some agents purchase professional liability insurance—called errors and omissions coverage—that in some cases may pay outstanding medical claims.

facts. DOL's enforcement actions apply to all states affected by the entity. To obtain a TRO, 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. 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 December 2003, DOL had obtained TROs 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 a permanent injunction. (See table 4.) Each of these actions affected people in at least 41 states. These three entities combined affected an estimated 25,000 policyholders and accounted for about \$39 million in unpaid claims.

Table 4: TROs and Injunctions for Three Unauthorized Entities, as of December 2003

Unauthorized entity	Number of states affected	TRO 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 TROs 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.

DOL and state officials told us that they coordinate their investigations and other efforts. For example, one EBSA regional director said his office has met with the states in the region and, when needed, provides information to help states obtain cease and desist orders to stop unauthorized entities. Furthermore, DOL officials said that they rely on the states to obtain cease

and desist orders to stop these entities' activities in individual states while conducting the federal investigations. For example, DOL and states coordinated and cooperated extensively during the investigation of Employers Mutual and provided mutual support in obtaining cease and desist orders and the TRO. Several states issued cease and desist orders against this entity before DOL obtained the TRO. In addition, DOL officials said DOL does not take enforcement action in some cases where (1) states have successfully issued cease and desist orders to protect consumers because no more action is needed to prevent additional harm, (2) the entity was expected to pay claims, or (3) the entity ceased operations.

From 2000 through 2002, EBSA opened investigations of 69 entities.¹⁷ These investigations involved 13 entities in 2000, 31 in 2001, and 25 in 2002.¹⁸ Overall, EBSA reported 67 civil and 17 criminal investigations opened from 2000 through 2002 involving the 69 entities. Civil investigations of these entities focused on ERISA violations, particularly breaches of ERISA's fiduciary requirements,¹⁹ while criminal investigations focused on such crimes as theft and embezzlement. In some cases, unauthorized entities can face simultaneous civil and criminal investigations. As of August 2003, EBSA was continuing to investigate 51 of these entities. As a result, further federal actions remain possible. For example, in addition to the three investigations that had yielded TROs 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.

States and DOL Alerted the Public and Used Other Methods to Help Prevent Unauthorized Entities from Continuing to Operate

To help prevent unauthorized entities from continuing to operate, officials in the insurance departments we interviewed in four states—Colorado, Florida, Georgia, and Texas—took various actions to alert the public and to inform insurance agents about these entities. NAIC developed model consumer and agent alerts to help states increase public awareness. DOL primarily targeted its prevention efforts to employer groups and small employers. The states and DOL emphasized the need for consumers and

¹⁷The states also identified 27 of these 69 entities.

¹⁸Based on the percentage of total investigative staff days spent on unauthorized entities, EBSA estimated that its field office costs for these investigations totaled about \$4.2 million for fiscal years 2000, 2001, and 2002 and the first 10 months of fiscal year 2003.

¹⁹For example, a fiduciary's failure to operate the plan prudently and for the exclusive benefit of the plan participants would be a fiduciary violation.

States Alerted Consumers and
Agents and Benefited from NAIC
Efforts

employers to check the legitimacy of health insurers before purchasing coverage, thus helping to prevent unauthorized entities from continuing to operate.

Insurance department officials we interviewed in 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. 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. (See app. IV.) 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. These states have also taken other actions to increase public awareness. For example, in April 2002, Florida released a public service announcement to television news markets throughout the state to warn about these entities. In addition, in the spring of 2003, Florida placed billboards throughout the state to warn the public through its "Verify Before You Buy" campaign. (See fig. 3.)

Figure 3: Florida's Public Awareness Campaign against Unauthorized Entities



Source: Florida Department of Financial Services.

In addition to increasing public awareness, the four state insurance departments alerted insurance agents about unauthorized entities. Using bulletins, newsletters, and other methods, these states warned agents about these entities, the implications associated with selling their products, and the need to verify the legitimacy of all entities. Georgia, for example, sent a warning to insurance agents in May 2002, which highlighted the characteristics of these entities, reminded agents that they could lose their licenses and be held liable for paying claims when the entities do not pay, and noted that the state insurance department Web site contained a list of all licensed entities. NAIC also developed a model agent alert to help agents identify these entities. A national association representing agents and brokers and many state insurance departments distributed this alert. The Web sites for the four states' insurance departments contained information on the enforcement actions they took against agents. The Texas insurance department's Web site, for example, provided the disciplinary actions that the state took as of August 2003 against individuals who acted as agents for unauthorized insurers. These agents were fined, ordered to make

	restitution, lost their licenses, or faced a combination of some or all of these actions.
DOL Alerted Employer Groups and Provided Guidance and Assistance to States and Others	DOL primarily focused its efforts to prevent unauthorized entities from continuing to operate on employer groups, small employers, and the states. 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. Consistent with the advice states provided, among other things, the tips advised small employers to verify with a state insurance department whether any unfamiliar companies or agents were licensed to sell health benefits coverage. (See app. V.) Also, the three EBSA regional offices we reviewed had 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. Federal and state representatives discussed ERISA-related issues and their investigations at these conferences. Furthermore, since 2000, DOL initiated several technical assistance efforts to help states and others better understand ERISA-related issues. These efforts are intended to help prevent unauthorized entities from avoiding state regulation. ²⁰
Agency and Other External Comments	We provided a draft of this report to DOL, NAIC, and the four state insurance departments (Colorado, Florida, Georgia, and Texas) whose officials we interviewed. DOL, NAIC, Florida, and Texas provided written comments on the draft. Colorado and Georgia did not provide comments on the draft.

²⁰For example, DOL updated and rereleased its publication, *Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation* (Washington, D.C.: 2003), which is intended to facilitate state regulatory and enforcement efforts regarding MEWAs as well as federal and state coordination. DOL distributed the publication to states and provided copies to others who made requests through DOL's toll-free hotline. Also, from January 2000 through October 15, 2003, DOL issued 13 advisory opinion and information letters regarding ERISA preemption and state insurance regulation of MEWAs to assist state regulators and prosecutors in enforcing state insurance laws against unauthorized entities. DOL has issued over 100 letters on MEWAs or similar types of arrangements since ERISA was enacted in 1974.

DOL identified initiatives it has taken to improve coordination with states and law enforcement agencies and highlighted its criminal enforcement actions. We modified the report to include additional examples of this coordination, such as the Atlanta EBSA regional office's meetings with states and coordination on investigation and enforcement actions. We recognize other activities are underway, such as making available electronic information that MEWAs are required to report to EBSA and sharing information with law enforcement agencies, but it was not the purpose of this report to identify the full range of DOL activities related to MEWAs and coordination with states on employer benefit and insurance issues. Although DOL also provided additional information on its criminal enforcement actions, we did not include these data in the report because these enforcement actions did not all relate to the investigations of the 69 entities DOL opened from 2000 through 2002 that were the focus of our analysis. DOL's comments are reprinted in appendix VI.

NAIC's written comments provided additional information on efforts it has taken to increase awareness of unauthorized insurance and acknowledged the difficulties associated with determining the number of unique unauthorized entities. NAIC noted that it began a national media campaign on unauthorized insurance that will run from January through June 2004 and, as part of the campaign, it developed a new brochure for consumers entitled "Make Sure Before You Insure." In addition, NAIC is updating its *ERISA Handbook*, which contains basic information about ERISA and its interaction with state law, to highlight different types of unauthorized entities and to provide guidance to state regulators on recognizing and shutting down these entities. Because NAIC recently initiated its media campaign and its scope was continuing to develop at the time we completed our work, we did not incorporate this information in the body of the report. In addition to the report's description of consumer and agent alerts that NAIC had distributed, NAIC also noted that in June 2003 it distributed a model regulatory alert to all its members that emphasized the need for third-party administrators and others to ensure that they do not become unwitting supporters of these entities. NAIC also suggested that the report include a more comprehensive list of state insurance regulation and laws. While the draft report included key functions that state insurance departments perform in regulating health insurance, it was beyond the scope of this report to comprehensively address the extent and variety of state insurance requirements affecting health insurance. We did, however, add a reference in the final report to consumer protection laws that states are responsible for enforcing. Finally, NAIC commented that many entities may be operating under multiple names, which makes it difficult to

precisely count the number of such entities. As discussed in the draft report, our estimates of the number of unique unauthorized entities attempted to account for this complexity by consolidating information from multiple states or DOL where there was information to link entities. We added additional information to the report's methodology to highlight the steps we took to determine the number of these entities.

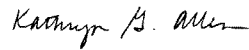
Written comments from the Florida Department of Financial Services noted that there has been cooperation among the federal and state governments in addressing the problems associated with unauthorized entities, stating that no state or federal agency effort could succeed without regulators sharing information. In addition, Florida stressed how unauthorized entities rely on associated entities and persons to succeed and proliferate. For example, unauthorized entities used licensed and unlicensed reinsurers, third-party administrators, and agents to help defraud the public. Florida indicated that these structures made it difficult for states to detect the entities.

In its written comments, the Texas Department of Insurance suggested that we further elaborate on legal actions states have taken against unauthorized entities. In addition to issuing cease and desist orders, Texas stressed that states have (1) used restraining orders and injunctions, similar to DOL, to stop unauthorized entities, (2) assessed penalties against operators of these entities, and (3) taken actions against agents who sold unauthorized products. For example, in 2002, Texas placed a major entity into receivership, seized its assets, and initiated actions to recover more assets. In 2003, Texas finalized penalties against the operators of Employers Mutual. In addition, Texas explained that states have devoted significant resources to penalizing agents who have accepted commissions from unauthorized entities. In addition to actions we reported, the Texas Department of Insurance indicated that it has taken other steps to increase consumer awareness of these entities. For example, Texas said that it had issued a bulletin to all health insurance companies and claims administrators warning about unauthorized entities and provided public information to various news organizations, assisting them with their reporting on these entities. Texas also highlighted the criminal investigations the state has conducted and wrote that its insurance fraud division has referred cases to DOL and others. While the report includes illustrative examples of key legal actions, including actions against agents involved with unauthorized entities, and public awareness efforts taken by the states, we primarily focused on the more common actions taken by states as reported in response to our survey.

DOL and the other reviewers also provided technical comments that we incorporated as appropriate.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its date. We will then send copies to the Secretary of Labor, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

Please call me at (202) 512-7118 or John E. Dicken at (202) 512-7043 if you have additional questions. Joseph A. Petko, Matthew L. Puglisi, Rashmi Agarwal, George Bogart, and Paul Desaulniers were major contributors to this report.



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Methodology for Identifying Unauthorized Entities

To identify the number of unique unauthorized entities nationwide from 2000 through 2002 and to obtain information, such as the number of employers covered and unpaid claims, pertaining to each of these entities, we obtained and analyzed data from state and federal sources. We obtained state-level data through a survey we sent to officials located in insurance departments or equivalent offices in all 50 states and the District of Columbia and federal-level data from the Department of Labor's (DOL) Employee Benefits Security Administration (EBSA). We also obtained information from the states on a related type of problematic arrangement—discount plans that sometimes are misrepresented as health insurance.

Survey of State Insurance Departments

To obtain data on unauthorized entities and other types of problematic plans in each state, we e-mailed a survey to individuals identified by the National Association of Insurance Commissioners (NAIC) as each state insurance department's multiple employer welfare arrangement (MEWA) contact. A NAIC official indicated that these individuals would be the most knowledgeable in the states on the issue of unauthorized entities. All the states responded to our survey.

Part I of the survey asked for selected data elements on the entities. We asked the 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 health insurance scams." First, we asked officials in each state to tell us how many of these entities covering individuals in the state they identified during each of 3 calendar years—2000, 2001, and 2002. For each entity the state identified during the 3-year period, we requested information such as the (1) number of employers covered, (2) number of policyholders covered, (3) total amount of unpaid claims in the state, and (4) amount of unpaid claims recovered. We also obtained information on the type of the entity, how the state identified the entity, and what actions the state took regarding the entity. Part II of the survey collected information on other types of problematic plans—including discount plans—and whether these other types of plans targeted small employers.

To determine the number of entities states identified in each calendar year, we relied on states to determine at what stage of their investigative process they would deem an entity to be unauthorized. Therefore, states could have reported both those entities they determined were unauthorized after completing an investigation and against which they took formal action and

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Methodology for Identifying Unauthorized
Entities

those entities still being investigated and for which no formal action had been taken.

Federal Data on Unauthorized Entity Investigations

To obtain federal-level data on unauthorized entities, we asked EBSA to provide data from the civil and criminal case investigations it opened from 2000 through 2002 involving these entities. To identify which of its civil and criminal investigations of employer-based health benefits plans fell within the scope of our research, we asked EBSA to use a similar definition of unauthorized entities as included on our state survey. For each of the civil and criminal investigations of these entities EBSA opened during the 3-year period, we asked EBSA to provide the same type of data about unauthorized entities that we requested on the survey we sent to all the states.¹ In addition, we asked EBSA to identify all the states that were affected by each entity it was investigating—information that states could not easily provide. Furthermore, where EBSA was conducting both civil and criminal investigations of an entity, we asked it to report that entity only one time.

Because EBSA and states provided the names of entities that were still under investigation at the time of our survey, we agreed not to report the names of any of these entities unless the investigation had already been made public. Therefore, we report only the names of three unauthorized entities for which DOL had issued media releases when it obtained temporary restraining orders (TRO) or injunctions to stop their activities.

Consolidating State and Federal Data on Unauthorized Entities

To determine the number of unauthorized entities that operated from 2000 through 2002, we analyzed information on the entities identified by the states and investigated by EBSA. Specifically, we analyzed the names of 288 entities that states identified and 69 entities that EBSA investigated.² In many cases, two or more states or EBSA reported the name of the same entity. We compared the entity names and, using several data sources—for

¹EBSA provided the data that it collected on the number of participants in these entities, whereas states reported on the number of policyholders. We consolidated the data reported by DOL and states and refer to these data as policyholders.

²Nine of the 51 states responding to our survey did not identify any unauthorized entities from 2000 through 2002. EBSA conducted three separate investigations that we determined related to different components of one large entity identified by several states.

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example, copies of the cease and desist orders states provided to NAIC, interviews of state officials, survey responses that included multiple names for the same entity, and media reports—and our judgment regarding similar names, consolidated them into a count of unique entities. Based on this analysis, we consolidated the 357 entity names identified or investigated by the states and EBSA to 144 unique unauthorized entities nationwide, including 77 entities identified only by the states; 40 entities investigated only by EBSA; and 27 entities identified by one or more states and also investigated by EBSA.

To identify the total number of employers covered, policyholders covered, amount of unpaid claims, and recoveries on the claims for the 144 unique unauthorized entities identified nationwide from 2000 through 2002, we consolidated the data provided by the states and EBSA. To develop unduplicated counts for each of the data elements, we developed a data protocol. We matched the names of the states that reported each of these 27 entities to the names of the states in which EBSA reported that these entities operated. Because the EBSA data generally were more consistent and comprehensive—particularly since not all states reported on some of the multistate entities reported by EBSA—we used the EBSA-reported data rather than the state-reported data for each element. However, if a state reported an entity to us and EBSA did not report that it was aware that the entity operated in that state, we included that state's data. Also, where EBSA data were missing for a data element, we included state-reported data in our totals when provided.³

To identify the year that each of the 144 unauthorized entities was identified, we used the earliest year either EBSA or a state reported for when each of the 144 entities was identified. To determine how many entities operated in each state, we combined the EBSA data and the data reported by the states. Because some of the entities EBSA investigated were nationwide or were in multiple states, the number of entities we report as operating in each state is greater than the number of entities states directly identified on our survey. For example, while nine states reported to us that they did not identify any entities from 2000 through

³For example, for one of the 27 entities that both EBSA and states identified, EBSA reported that it operated in 13 states, 7 of which also reported this entity to us. In addition, 1 other state, not identified by EBSA, reported this entity to us and we included this state's data. Also, because EBSA did not provide any data on the number of employers and policyholders for this entity, we used the data reported by the 8 states.

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2002, EBSA indicated that several of the entities it was investigating operated in these states.

The data we report for each of the elements—the number of employers covered, policyholders covered, amount of unpaid claims, and recoveries on the claims—may be underestimated. EBSA and some states reported that some of the data were unknown for each of these elements. In addition, while the states provided most of the requested data, they did not provide some of the data for some entities. Furthermore, in several cases, EBSA and the states provided a range in response to our request for data. When they did this, we used the lowest number in the range. For example, whereas EBSA reported unpaid claims for one of these entities from \$13 million to \$20 million, we reported unpaid claims as \$13 million. In some cases, EBSA and the states reported that the data they provided were estimated.

Employers Mutual, LLC and Federal and State Actions

Employers Mutual, LLC was one of the most widespread unauthorized entities operating in recent years, covering a significant number of employers and policyholders and accounting for millions of dollars in unpaid claims during a 10-month period in 2001. According to court documents and DOL, four of the entity's principals were associated with the collection of approximately \$16 million in premiums from over 22,000 people and with the entity's nonpayment of more than \$24 million in medical claims. DOL and states took actions to terminate Employers Mutual's operations and an independent fiduciary was appointed by a U.S. district court in December 2001 to administer the entity and, if necessary, implement its orderly termination. In September 2003, the court ordered the principals to pay \$7.3 million for their breach of fiduciary responsibilities.

Employers Mutual Created Associations, Hired Firms, and Paid Companies Established by Its Principals

Employers Mutual was established in Nevada in July 2000 and began operations in January 2001.¹ The name Employers Mutual is similar to Employers Mutual Casualty Company, a long-established Iowa-based insurance company marketed throughout the United States, which had no affiliation with Employers Mutual. By February 2001, Employers Mutual had established 16 associations covering a wide array of industries and professions, such as the American Coalition of Consumers and the National Association of Transportation Workers, that created employee health benefit plans for association members to join.² Employers Mutual was responsible for managing the plans offered through these 16 associations, which claimed to be fully funded and were created to cover certain medical expenses of enrolled participants. Employers Mutual ultimately claimed that its association structure did not require it to register or to seek licensure from states, and that it also precluded the entity from DOL

¹Prior to Employers Mutual's creation, one of its principals was associated with other unauthorized entities.

²The other associations were the American Association of Agriculture, the Association of Automotive Dealers and Mechanics, the Association of Barristers and Legal Aids, the Communications Trade Workers Association, the Construction Trade Workers Association, the Association of Cosmetologists, the Culinary and Food Services Workers Association, the Association of Educators, the Association of Health Care Workers, the National Alliance of Hospitality and Innkeepers, the Association of Manufacturers and Wholesalers, the Association of Real Estate Agents, the Association of Retail Sellers, and the National Coalition of Independent Truckers. Employers Mutual also sold coverage through existing associations such as the National Writers Union, an association representing approximately 7,000 freelance writers.

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Employers Mutual, LLC and Federal and
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regulation under the Employee Retirement Income Security Act of 1974 (ERISA).

Employers Mutual's principals contracted with legitimate firms to market the plans and process the claims, and with their own companies purportedly to provide health care and investment services. Licensed insurance agents marketed the 16 plans nationwide. Employers Mutual hired a firm to process the claims from members of its associations' employee health benefits plans and to handle other administrative tasks from January 2001 until the firm terminated its services in October 2001 for, among other reasons, nonpayment of a bill. According to court filings, Employers Mutual also contracted with four firms, purportedly health care provider networks and investment firms, established and owned by Employers Mutual principals. A district court later cited evidence that the provider networks were paid despite the fact that one of them had no employees and provided no services to plan members.³ Furthermore, the district court noted that no contracts between the investment firms and Employers Mutual were presented into evidence and no information was introduced concerning the services these firms performed for this entity.

**Employers Mutual
Collected About
\$16 Million in
Premiums but Did Not
Pay over \$24 Million in
Medical Claims**

From the time Employers Mutual commenced operations in January 2001 through October 2001, more than 22,000 policyholders in all 50 states and the District of Columbia paid approximately \$16.1 million in premiums. According to court documents and the independent fiduciary appointed to administer Employers Mutual, one of this entity's principals allegedly set the premiums for the 16 plans after he calculated the average of sample rates posted by other insurance companies on the Internet and reduced them to ensure that Employers Mutual would offer competitive prices.

DOL has determined that of the \$16.1 million collected in premiums, Employers Mutual paid about \$4.8 million in medical claims. According to DOL, the principals made payments for other purposes besides the payment of claims, including about \$2.1 million in marketing, about \$0.6 million in claims processing, and about \$1.9 million to themselves or their companies. Approximately \$1.9 million in Employers Mutual's assets had been recovered by the independent fiduciary since his appointment in

³*Chao v. Graf*, No. 01-0698, 2002 WL 1311122 (D. Nev. Feb. 1, 2002) (order granting preliminary injunction).

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Employers Mutual, LLC and Federal and
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December 2001 through February 2004.⁴ The independent fiduciary and DOL reported that they were prevented from fully accounting for the money collected and paid out by Employers Mutual, its principals, and contracted companies due to the scope of its operations and the disarray and incompleteness of the records they were able to recover.

The independent fiduciary reported that insurance claims totaling over \$24 million remain unpaid as of February 2004. He paid \$134,000 to a prescription service provider immediately after his appointment, and no additional medical claims have been paid. In March 2003, the fiduciary filed suit in federal court to recover the unpaid claims from the insurance agents who marketed Employers Mutual plans.

States, Then DOL,
Acted against
Employers Mutual

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 law.⁵ Nevada therefore issued a cease and desist order against Employers Mutual in June 2001.⁶ In August 2001, Florida insurance regulators found that Employers Mutual was engaged in the business of insurance, including operating as a MEWA, without a certificate of authority⁷ as required by Florida law.⁸ Florida ordered Employers Mutual to stop selling insurance within Florida's borders pending an appeal by the entity, although at the time the state did not find evidence of delays or failures to pay medical claims. Other states, including Alabama, Colorado, Oklahoma, Texas, and Washington, filed cease and desist orders against Employers Mutual by December 2001.

⁴The independent fiduciary has spent about \$1.6 million of the \$1.9 million seized, primarily for the administrative cost of processing approximately 100,000 claims that had not been adjudicated and for legal and other costs, with approximately \$0.3 million remaining as of February 2004. The U.S. District Court in Nevada ordered the independent fiduciary to process all unadjudicated claims in its February 1, 2002 order granting a preliminary injunction.

⁵Nev. Rev. Stat. §§ 685B.030, 685B.035 (2003).

⁶Cease and Desist Order: Employers Mutual, L.L.C., Nevada Department of Business and Industry Division of Insurance case no. 01.658 (June 14, 2001).

⁷Immediate Final Order in the matter of Employers Mutual, L.L.C., Florida Department of Insurance case no. 42659-01-CO (Aug. 14, 2001).

⁸Fla. Stat. ch. 624.401, 624.437 (2003).

Appendix II
Employers Mutual, LLC and Federal and
State Actions

On November 21, 2001, the Nevada Commissioner of Insurance signed an Order of Seizure and Supervision seizing and taking possession of Employers Mutual funds held in Nevada bank accounts and granting the Nevada Commissioner supervision over the assets of Employers Mutual in Nevada.⁹ Nevada also reported that it engaged in a discussion involving 26 state insurance departments that led to an agreement with Employers Mutual to facilitate payments of claims nationwide. On December 13, 2001, the U.S. District Court for the District of Nevada granted a TRO against Employers Mutual and its four principals,¹⁰ and on December 20, 2001, the Nevada Commissioner surrendered all of Employers Mutual's assets that she had recently seized to the independent fiduciary. In the TRO, DOL alleged that the principals

- used plan assets to benefit themselves;
- failed to discharge their obligations as fiduciaries with the loyalty, care, skill, and prudence required by ERISA; and
- paid excessive compensation for services provided to Employers Mutual.

The TRO temporarily froze the assets of all the principals involved in this entity and prohibited them from 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.

After a subsequent hearing, the U.S. District Court for the District of Nevada issued a preliminary injunction on February 1, 2002, leading to the interim shutdown of Employers Mutual nationwide.¹¹ On April 30, 2002, the same court issued a quasi-bankruptcy order establishing a procedure for the orderly dissolution of the plans and payment of claims with assets

⁹Employers Mutual, L.L.C., Nevada Department of Business and Industry Division of Insurance case no. 01.658 (Nov. 21, 2001).

¹⁰*Chao v. Graf*, No. 01-0698, (D. Nev. Dec. 13, 2001) (order granting temporary restraining order).

¹¹*Chao v. Graf*, No. 01-0698, 2002 WL 1311122 (D. Nev. Feb. 1, 2002) (order granting preliminary injunction).

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State Actions

recovered by DOL and the independent fiduciary.¹² On September 10, 2003, the 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.¹³

In March 2003, the independent fiduciary filed suit in Nevada on behalf of the participants against Employers Mutual's principals alleging, among other things, that they participated in racketeering, fraud, and conspiracy. The independent fiduciary also sued the insurance agents, who either marketed or sold the plans, for malpractice as part of that action. The fiduciary has requested damages and relief for unpaid or unreimbursed claims. In October 2003, the court ordered the suit to mediation in February 2004. The fiduciary and some agents, before the beginning of mediation, reached a proposed settlement that was before the court for approval as of February 2004.

Figure 4 contains a chronology of events from Employers Mutual's establishment to state and federal actions to shut it down.

¹²*Chao v. Graf*, No. 01-0698 (D. Nev. Apr. 30, 2002) (order establishing a quasi-bankruptcy).

¹³*Chao v. Graf*, No. 01-0698 (D. Nev. Sept. 10, 2003) (order granting permanent injunction).

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Employers Mutual, LLC and Federal and
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Figure 4: Key Events of Employers Mutual 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 - December 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.

Appendix II
Employers Mutual, LLC and Federal and
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Note: Includes information from the preliminary injunction, the permanent injunction, and cease and desist orders from, Alabama, Colorado, Florida, Nevada, Oklahoma, Texas, and Washington.

*All subsequent references to the U.S. District Court in this figure refer to the U.S. District Court for the District of Nevada.

Discount Plans Have Been Marketed as Health Insurance in Some States

Plans that provide reduced rates for selected medical services rather than comprehensive health insurance benefits are known as discount plans. These plans are not health insurance as they do not assume any financial risk. Discount plans were marketed in most states. However, in some states, discount plans were inappropriately marketed by using health insurance terms and these misrepresented plans were targeted to small employers.

Overview of Discount Plans

Discount plans charge consumers a monthly membership fee in exchange for a list of health care professionals and others who will provide their services at a discounted rate. Because they do not assume any financial risk or pay any health care claims, discount plans are not health insurance. Most often, these plans provide discounts for such services as physicians, dental care, vision care, or pharmacy. Some may also provide discounts for services provided by hospitals, ambulances, chiropractors, and other types of specialty medical care. The discounts offered and monthly fees vary by plan. For example, a consumer may pay \$10 per month to a discount plan for access to lower cost dental services. A dentist participating in the discount plan may charge plan members 20 percent less than nonmembers. Therefore, if the fee is typically \$60 for a dentist to perform certain procedures that help prevent disease—for example, removing plaque and tartar deposits from teeth—the plan member will pay a discounted fee of \$48 to the dentist.

Most state insurance departments do not regulate discount plans because they are not considered to be health insurance. None of the insurance departments in the states that we reviewed—Colorado, Florida, Georgia, and Texas—regulated discount plans. Thus, according to a state official, 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. When consumers complain about discount plans in Colorado, for example, the insurance department refers the complaints to the Attorney General.¹

¹To alert consumers to discount plans, the Colorado insurance department, along with the Colorado Attorney General, issued a joint publication highlighting purchasing tips and potential problems—Colorado Division of Insurance and the Colorado Attorney General, "Discount Health Plans, What Consumers Should Know About Discount Health Plans," October 2002.

Appendix III
Discount Plans Have Been Marketed as
Health Insurance in Some States

State officials indicated that discount plans are not problematic as long as companies market and advertise these plans accurately and consumers understand that these products are not health insurance. Advertisements for discount plans can be found on the Internet, through infomercials on television, on the radio, in local newspapers, on signs posted along roadways, in unsolicited "spam" e-mails or faxes, and in direct marketing and mailings. According to state officials, discount plans have positive and negative aspects. They said that discount plans can save some money for people who do not have health insurance and who know they will be using health care services. In addition, they said consumers can use these plans to augment health insurance policies providing only catastrophic coverage. However, they said that consumers needed to understand that using discount plans can result in higher out-of-pocket costs than typical health insurance. For example, getting a 20 percent discount on heart-bypass surgery at the average U.S. charge could still cost an individual about \$40,000 out-of-pocket. Furthermore, it can be difficult for consumers to determine if providers are actually giving them a discount, as most providers do not list their charges.

**Discount Plans
Misrepresented in
Some States**

Discount plans were sold in most states. About 78 percent of the states responding to our survey (40 of 51 states) reported that discount plans were sold within their borders from 2000 through 2002. (See table 5.) Most states that reported discount plans were sold within their borders also reported that these plans were not marketed as health insurance. Most of the states that reported discount plans from 2000 through 2002 did not indicate any problems with how they were advertised.

Appendix III
Discount Plans Have Been Marketed as
Health Insurance in Some States

Table 5: States' Experience with Discount Plans, 2000-2002

States' experience with discount plans	Number of states
Discount plans were sold	
• Plans were not marketed as health insurance	17
• Plans were sometimes marketed as health insurance	14
• Plans were sold but states did not know if the plans were marketed as health insurance or states did not provide information	9
Subtotal	40
Discount plans were not sold	9
States either did not know if discount plans were sold or did not provide information	2
Total	51

Source: GAO analysis of data reported by states.

Fourteen states reported that discount plans were misrepresented as health insurance to some degree.² For example, the Texas insurance department reported that it reviewed discount plans' advertising materials that consumers and insurance agents brought to its attention. According to a state insurance department official, one issue that repeatedly arose with the marketing materials that the state reviewed was that some discount plans were inappropriately advertised as "health plans," as "health benefits," or with some other phrase similar to insurance. Furthermore, this official said that many discount plans had been marketed in Texas. Connecticut officials, however, were aware of only one discount plan, an out-of-state entity, which inappropriately advertised in the state as a "medical plan" providing affordable health care to families and individuals. The state officials reported that they did not know whether any Connecticut residents had subscribed. Utah officials reported that insurance terms were inappropriately used—for example, all preexisting conditions were immediately accepted and everyone was accepted regardless of medical history. According to Utah officials, advertisements did not usually state that they were discount plans and not health insurance, but when they did, the print was small and was hard to read.

²The 14 states were Alabama, Arkansas, Connecticut, Indiana, Maine, Missouri, Nebraska, Oklahoma, South Carolina, Tennessee, Texas, Utah, Washington, and Wyoming.

Appendix III
Discount Plans Have Been Marketed as
Health Insurance in Some States

As with unauthorized entities, small employers may be particularly vulnerable to discount plans that are misrepresented as insurance. Officials in 8 of the 14 states that reported discount plans were misrepresented as insurance also reported that the discount plans were marketed to small employers. These eight states were Maine, Nebraska, Oklahoma, Tennessee, Texas, Utah, Washington, and Wyoming.

Appendix IV

Consumer Alert Developed by the National Association of Insurance Commissioners

In the fall of 2001, NAIC developed a consumer alert to help prevent unauthorized entities from operating. This alert is intended to be a model states can use to help inform the public about these entities. NAIC distributed the consumer alert to all the states and also made it available on its Web site. The alert provides tips that consumers can follow to help protect themselves from the entities and sources to contact for additional information about these entities. (See fig. 5.)

Appendix IV
Consumer Alert Developed by the National
Association of Insurance Commissioners

Figure 5: Consumer Alert from NAIC

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Consumer Alert from the NAIC:
Protect Yourself Against Illegal Health Plans

If it seems too good to be true, it probably is. Nationwide, the health insurance marketplace is facing tough times. The cost of health insurance is rising. Those seeking to make a profit by selling fraudulent health insurance claim that state insurance laws don't apply. These entities recruit insurance agents to sell "ERISA plans" or "union plans" that falsely claim to be exempt from state law. Here are some tips from the National Association of Insurance Commissioners (NAIC) to help you protect yourself against illegal health insurance plans.

- 1. Legitimate ERISA Plans**
 Legitimate ERISA plans (plans governed by the federal Employee Retirement Income Security Act of 1974) and union plans may be exempt from state insurance regulation, which is why criminals try to fool people by making these claims. However, legitimate ERISA or union plans are established by a union for its own members or by an employer for the employer's own employees. They are not sold by insurance agents.
- 2. Get the Facts**
 Consumers and employers should take care to ask their agents whether the health coverage they are purchasing is fully insured by licensed insurers. A "union plan" sold by an agent, health coverage that seems unusually "cheap," health coverage that is issued with few questions about the applicant's health condition or plan material that refers only to a "stop-loss" insurer should alert a consumer to question the selling agent or contact the state insurance department.
- 3. How the Scam Works**
 A typical fraudulent health insurance scam attempts to recruit as many local insurance agents as possible to market the coverage. The health coverage is not approved by the state insurance department. Agents are told it is regulated by federal, not state law. In fact, it is totally illegal. The coverage is typically offered regardless of the applicant's health condition and at lower rates and with better benefits than can be found from licensed insurers. The scam seeks to collect a large amount of premiums as rapidly as possible.

 While claims may be paid initially, the scammers will soon begin to delay payment and offer excuses for failure to pay. Unsuspecting consumers who thought they were covered for their medical needs are left responsible for huge medical bills. Employers may be liable for the medical bills of their employees as well.
- 4. Avoid Becoming the Next Victim**
 How can the average consumer avoid becoming the next victim? Ask hard questions and do your homework. Read all materials and scrutinize Web sites carefully. Here are some circumstances and product characteristics that should prompt consumers to question a health plan before purchasing it. These include:
 - Coverage that boasts low rates and minimal or no underwriting should be a signal to look deeper.
 - Make sure your insurance agent is selling a state-licensed insurance product. If an insurance agent is trying to sell you a union plan, report them to your state insurance department.
 - Deal with reputable agents. If the person trying to sell you coverage says he or she doesn't need a license because the coverage isn't insurance or is exempt from regulation, watch out. Contact your state insurance department if you have any questions.
 - Ask your agent for the name of the insurer and check the benefit booklet you receive to see whether it names a licensed insurer that is fully insuring the coverage.
 - If your agent or the marketing material says that the plan is covered only by "stop-loss insurance" or that the plan is an "ERISA" or "union" plan, contact your state insurance department.
- 5. Get More Information**
 Your state insurance department is your best source for information on company and agent licensing requirements, as well as available products. For a list of state health contacts, visit www.naic.org and click on MEWA Contacts. You can also link to your insurance department's Web site by clicking on "State Insurance Regulatory Web Sites," then click on your state.

The National Association of Insurance Commissioners is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and four U.S. territories. The overriding objectives of state regulators are to protect consumers and help maintain the financial stability of the insurance industry. If you would like more information or wish to be removed from the "Consumer Alert" mailing list, please contact the Communications Department at (816) 642-3660 or Communications@naic.org.

Source: Reprinted with permission from NAIC. Further reprint or redistribution is strictly prohibited.

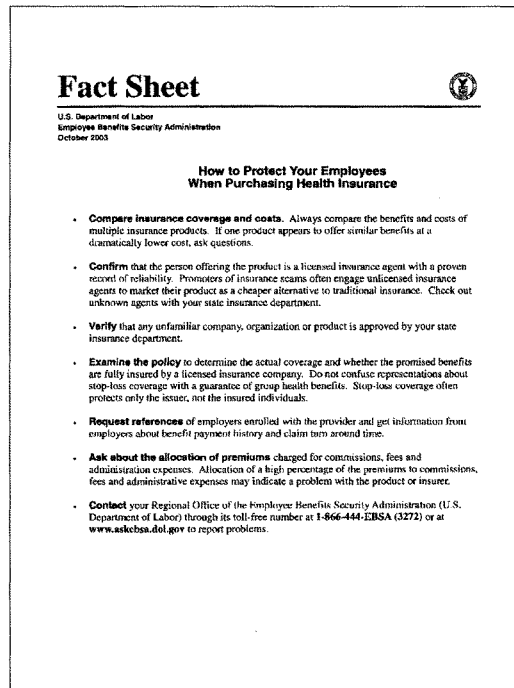
Department of Labor Memorandum and Insurance Tips for Small Employers

On August 6, 2002, the Secretary of Labor sent a memorandum to over 70 business leaders and associations asking them to distribute insurance tips for small employers to follow when they purchased health insurance for their employees.¹ Because, according to the Secretary, “scam artists” were aggressively targeting small employers and their employees, the Secretary advised small employers to take extra precautions when obtaining health care coverage. The tips, entitled “How to Protect Your Employees When Purchasing Health Insurance,” informed small employers that, among other things, they should verify with a state insurance department whether any unfamiliar companies or agents were licensed to sell health benefits coverage. DOL has updated these tips and makes them available on its Web site. Figure 6 includes the current version of DOL’s tips.

¹DOL sent the memorandum to such groups as the Independent Insurance Agents of America, National Association for the Self-Employed, National Federation of Independent Business, National Restaurant Association, Society of Professional Benefit Administrators, and the U.S. Chamber of Commerce.

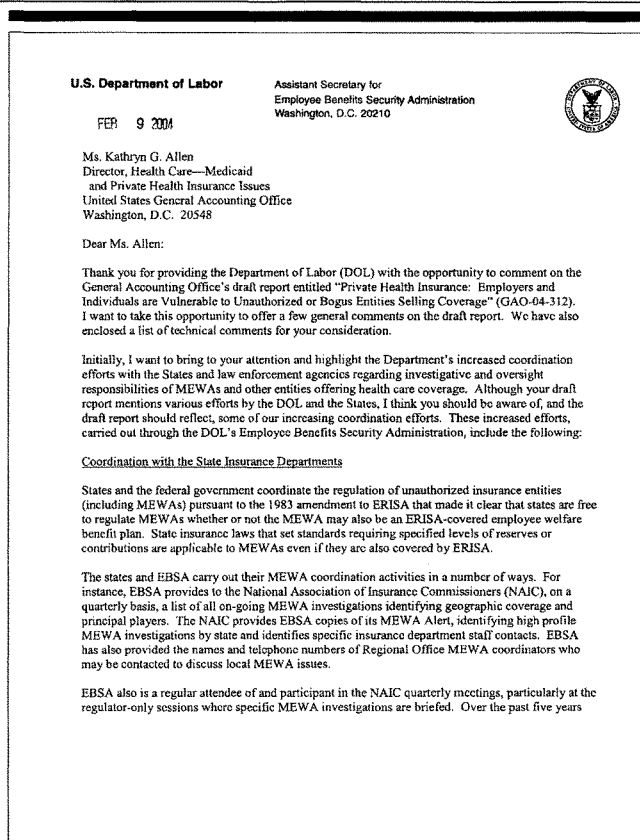
Appendix V
Department of Labor Memorandum and
Insurance Tips for Small Employers

Figure 6: Insurance Tips for Small Employers



Source: DOL.

Comments from the Department of Labor



Appendix VI
Comments from the Department of Labor

EBSA has participated in twenty of the NAIC quarterly meetings to exchange information about health issues that are of concern to government regulators. Finally, EBSA has established a web site that will enable state regulators to electronically access information filed with EBSA concerning MEWAs (Form M-1).

More locally, EBSA field offices have invited state regulators in their jurisdiction to attend MEWA training sessions to discuss their current investigations. Successful examples of this type of coordination activities are the multi-state events sponsored by EBSA's Atlanta Region on technical ERISA MEWA issues and included detailed discussions of actual investigations. There were one or more representatives from the insurance departments of GA, SC, NC, TN, MS, AL, FL, AK, LA and TX at these conferences as well as Fred Nepple from Wisconsin's Attorney General's office, and Chair of the NAIC ERISA working group.

In addition to sharing information, EBSA and state regulators often will actively work together during the investigative stages of a MEWA case and provide mutual support to obtain Cease and Desist Orders and Temporary Restraining Orders to provide protection for MEWA participants. A notable example of this type of cooperation is the investigation of Employers Mutual LLC, which, as is more fully described in the report, involved a MEWA that provided health benefits to more than 23,000 participants and beneficiaries in all 50 states. The Department's investigation disclosed numerous instances where monies were allegedly transferred from the MEWA to the MEWA's operators to pay excessive expenses rather than paying benefits for the participants. Because of the multi-state nature of this MEWA's operations, close coordination with the States was essential, particularly in Nevada. Cease and Desist Orders were issued by the departments of insurance in numerous states including: Florida, Nevada, Illinois, Texas, Iowa, Washington, Pennsylvania, Massachusetts, Arizona, and Colorado.

EBSA Criminal Enforcement Efforts Related to MEWAs

In addition to EBSA's civil enforcement actions, EBSA has also pursued operators of fraudulent MEWAs for criminal prosecution. From 2000 to 2003, EBSA has conducted criminal investigations which have led to ten indictments. During this time, 11 individuals have also pled guilty to crimes related to EBSA criminal MEWA investigations. Currently, there are 28 open criminal investigations on MEWAs. Because of grand jury secrecy requirements, EBSA cannot disclose any potential indictments that may result from these investigations.

Additionally, EBSA has made efforts to inform other law enforcement agencies of the continuing rise of fraudulent MEWAs. In August 2003, EBSA enforcement staff made presentations to over 30 supervisors of the FBI Health Care Fraud Task Force regarding fraudulent MEWAs. EBSA investigators will also be conducting a training session regarding MEWAs at the Federal Law Enforcement Training Center in February 2004. Lastly, EBSA has prepared for the NAIC a list of the relevant Title 18 crimes related to the prosecution of operators of fraudulent MEWAs.

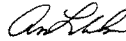
In closing, I hope that the above information and our enclosed technical comments are helpful for

-2-

Appendix VI
Comments from the Department of Labor

your preparation of the GAO report on unauthorized entities selling health insurance coverage. If there are any questions on these comments please contact Dan Maguire, Director, Office of Health Plan Standards and Compliance Assistance at (202) 219-7222, ext. 2103.

Sincerely,



Ann L. Combs
Assistant Secretary
Employee Benefits Security Administration

Enclosure

-3-

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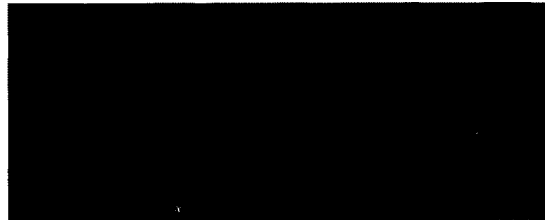
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RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

Question 1. Is this trend in the number of unauthorized entities still growing or has it peaked?

Answer. During the period that we examined—2000 through 2002—the number of unauthorized entities newly identified nearly doubled, from 31 to 60. However, it is not clear what the trend has been since 2002. We asked state and federal officials and experts if the number of unauthorized entities had increased since 2002, but their responses taken together did not point to any consistent trend. For example, one state official did not know if the numbers would continue to grow beyond 2002, while another state official said that his state experienced a decline in the number of these entities.

Increased federal, state, and media attention on this issue could result in an increase in the identification of these entities in the short-term, but the direction of a sustained long-term trend remains to be seen. For example, the National Association of Insurance Commissioners (NAIC) has enhanced its public awareness campaign with a new brochure and is updating its Employee Retirement Income Security Act (ERISA) Handbook to address these entities. Furthermore, your March 3 hearing and the recent release of reports on this topic have brought increased visibility to this issue. This increased federal, state, and public awareness could help identify more unauthorized entities in the short term and deter them in the long term.

Question 2. I realize that this is a fact-finding report looking at the extent of the problem nationwide. It seems to me that the next report should look at the effectiveness of the Department of Labor, and the involvement of the Department of Justice in their respective activities in identifying and stopping insurance scam artists? Is that the next logical step here Ms. Allen?

Answer. In light of the more than \$250 million in unpaid claims arising from the activities of unauthorized or bogus entities nationwide that we documented in our report, we agree that a more comprehensive review of the federal government's activities is warranted. As you know, the Department of Labor (DOL) is responsible for regulating employer-sponsored health benefits, including those offered through unions, to ensure compliance with federal ERISA requirements. DOL also shares a joint responsibility with the states to regulate multiple employer welfare arrangements. Some of the unauthorized or bogus entities that did not pay some or all of the legitimate health care claims filed by policyholders or those covered by the policies identified in our report claimed to be exempt from state insurance regulations because of ERISA. While our recent report described the type of actions DOL has taken to identify and stop these entities, we did not assess whether DOL's actions were effective. Therefore, we agree that the next step to take would be a study of the effectiveness of the federal government's efforts to identify and stop unauthorized or bogus entities.

RESPONSES TO QUESTIONS FROM SENATOR KERRY

Question 1. Did your study provide any insights into differences in state insurance regulatory and oversight capacity that could explain why some states had as few as 5 unauthorized entities while others had 25 or more? Are there policy implications from these findings that might improve the effectiveness of current insurance regulation and enforcement efforts at both the state and federal level?

Answer. As you note, we found that the number of unauthorized entities identified in each state varied from 5 to 31, with a concentration of these entities noted particularly in southern states. While we did not analyze the effectiveness of various regulatory and oversight procedures and capabilities at the state and federal level as part of this study, we did ask state and federal officials and experts if there was an association between a state's regulatory environment and the number of unauthorized entities identified within its borders. No such association was reported to us. Despite a higher prevalence of unauthorized entities in some states, several officials we interviewed indicated that in general states significantly affected by unauthorized entities enforced their regulations against them as energetically as states that were not as affected by these entities.

DOL and state officials and experts offered several potential reasons, but no definitive explanation, as to why these entities are concentrated in some states. For example, a DOL official noted that states with more of these entities, like Texas, often have large populations and many small employers, characteristics attractive to unauthorized entities because they represent more business opportunities. A state official suggested that operators might prefer states with large, rapidly growing metro-

politan areas adjacent to rural areas—for example, Atlanta—where an entity’s operators can settle anonymously in a large city and not travel far to find lower wage earners and small employers that are seeking affordable employee health benefits. However, while several such theories were offered, we did not find any common factors or characteristics among states with more of these entities that could consistently explain why so many of these entities operated in those states.

Question 2. In his closing remarks, Senator Grassley noted that he is going to request that GAO assess the effectiveness of DOL oversight of insurance scams and examine current coordination efforts among the states, NAIC, and the federal government in addressing this problem. Are there findings from this study that deserve particular emphasis as you move forward to examine these questions?

Answer. Our report on unauthorized and bogus entities identified several issues that could warrant further review. For example:

- We found that the Department of Labor obtained temporary restraining orders against three large national entities that they identified from 2000 through 2002, and in two of these cases, obtained injunctions. In other cases, the investigations remained ongoing at the time we did our work or DOL relied on state actions to stop the entity’s operations. Further examining the status of the investigations that had not yet resulted in enforcement action could help identify whether there are other opportunities for federal enforcement activity.
 - One Employee Benefits Security Administration (EBSA) regional office appeared to be particularly proactive in its efforts to identify and stop the activities of these entities. By further reviewing practices among different EBSA regional offices, “best practices” might be identified that, as appropriate, could be applied consistently across all the regional offices.
 - Our report showed that some of the methods that DOL used to share information and coordinate with states, NAIC, and others appeared to be informal. A further exploration of these methods would reveal whether DOL and the states’ methods for information sharing and coordination are sufficient and effective or whether more formalized or standardized procedures need to be implemented.
 - We found that pursuing federal enforcement action through temporary restraining orders and injunctions can be a lengthy process. The need for a federal mechanism to stop the activities of entities that violate ERISA requirements and to provide due process in the courts must be balanced with the need for timely resolutions of these cases to minimize the damage that unauthorized or bogus entities can cause nationwide.
-

Mr. Chairman and Members of the Committee:

My name is Marie Almond. I appreciate the opportunity to take part in this hearing to share my experience as a victim of the health insurance scam created and operated by Employers Mutual. In 2001, I owned a small medical consulting firm with two other individuals. In March of that year, our company purchased a small business health insurance plan from Employers Mutual and began paying premiums. My life quickly turned upside down within the next four months when I learned that I had breast cancer in July. I was devastated and suffered tremendous emotional stress. Unfortunately, my stress would later be compounded when I realized that Employers Mutual was not paying claims for my medical expenses. To date, there are outstanding medical bills of approximately \$71,000 that I incurred for procedures related to my breast cancer and treatments for other medical emergencies during the time that Employers Mutual should have been paying for claims.

Soon after discovering that I had breast cancer in July 2001, I underwent surgery, chemotherapy, and radiation treatments. As expected, these were costly procedures, totaling over \$65,000. As soon as I received my medical bills, I sent them to Employers Mutual for payment. Acting under the façade of a legitimate health insurer, Employers Mutual promptly responded by sending me a notice stating that my claim was being processed. Since Employers Mutual was purporting to be a legitimate company and there was no indication at that time that it was operating a health insurance scam, I believed that these and any future claims would be paid. Unfortunately, I would soon learn that Employers Mutual's claims of processing my bills were nothing more than a front to bide time for the company to receive premiums.

I instinctively felt that something was wrong when I learned that the medical bills had still not been paid during the next three months. Clearly, it did not take that long to process claims. I desperately needed answers, so I contacted the Tennessee Insurance Commissioner's Office to find out about Employers Mutual. To my horror, I learned that Employers Mutual was a Nevada corporation and was not licensed to sell insurance in Tennessee. My heart sank. Still needing answers to my questions about Employers Mutual, I decided to contact the Nevada Insurance Commissioner's Office to learn more. I learned that the state of Nevada had ordered Employers Mutual to stop operating its sham business.

Unfortunately, I soon learned that my problems with Employers Mutual would escalate when my doctor told me that I needed to have an operation immediately for another medical problem. My doctor strongly recommended that I receive treatment at a hospital in Germantown, Tennessee. I feared that I would ultimately be responsible for paying this procedure. The hospital subsequently refused to admit me because of the outstanding medical claims related to my breast cancer. With no other options and as a last resort, I reluctantly agreed to allow the procedure to be performed in my doctor's office. I simply had no other choice. My frustration with Employers Mutual mounted because the cost of this procedure was over \$6,000. I was at wit's end.

All during this time, Employers Mutual continued to purport to be a legitimate health insurance provider, claiming that my outstanding claims of \$71,000 were being processed. Employers Mutual carried this charade on into January 2002. However, the curtain fell on January 21, 2002

when the company finally admitted that a temporary restraining order had been issued against it and told me that I would not receive any benefits until the lawsuit against it was resolved.

At my age, the prospect of being uninsured is daunting. As a small business owner, I knew that the cost of coverage for my business would be exorbitant. Yet, I needed insurance and I needed it quickly. With no other recourse, I had to leave my company and start working for one of my company's competitors just to get insurance. I can't begin to explain the emotional turmoil that I suffered when I had to leave the company that I started and where I forged meaningful relationships ... just to obtain health insurance. To me, I was paying the ultimate price for Employers Mutual's sham operation.

Between January 2002 and October 2002, I was uninsured. Fortunately, there were no medical emergencies during this time. If there had been any, I would have been financially responsible for them. As of October 2002, Blue Cross/ Blue Shield of Georgia became my insurer. After my experiences with Employers Mutual, I was happy to be insured by a reputable company. However, for almost a year, I feared that I would be financially responsible for any medical problems that existed before my coverage with Blue Cross/ Blue Shield. These fears subsided in November 2003, when Blue Cross/ Blue Shield began paying for claims associated with pre-existing conditions.

Again, thank you for the opportunity to share my experience with you concerning Employers Mutual. I would be happy to answer any questions you might have.

**TESTIMONY OF ANN L. COMBS
ASSISTANT SECRETARY FOR EMPLOYEE BENEFITS SECURITY
U.S. DEPARTMENT OF LABOR
BEFORE THE SENATE FINANCE COMMITTEE
MARCH 3, 2004**

Introductory Remarks

Good morning, Chairman Grassley, Ranking Member Baucus, and members of the Committee. Thank you on behalf of the Department of Labor for inviting me to testify on behalf of the Employee Benefits Security Administration (EBSA), which has administered the Employee Retirement Income Security Act (ERISA) for almost 30 years. I commend this Committee for focusing today on insurance scams, and the effect they have on workers and their families, and on business owners who wish to provide health benefits.

Health insurance scam artists steal money from those who need it the most – people with pressing health needs who generally are not able to sort through the complicated world of health insurance and divert the funds to their own enrichment. Often, the victims only find that they have no health insurance after they have received care and the hospital or doctor bills them for the full amount, or have requested approval of a medical procedure. As we have heard from today's witnesses, a major illness or surgery can cost hundreds of thousands of dollars. These situations devastate workers and their families and threaten the financial security of thousands. Given their unique vulnerability, small

employers and workers in small businesses are the most susceptible to these scams.

Vulnerability of Small Business to Insurance Fraud

Small businesses are especially vulnerable to health insurance scams because of cost and adverse market conditions, such as:

- **High Costs** – First and foremost, their costs are higher. Small firms must pay as much as 20 to 30 percent more than large firms for comparable coverage.¹ And their costs are more volatile, rising 17 percent on average in 2003 among firms with 3 to 9 employees, compared with 13 percent among those with 200 or more.²
- **Low Coverage** – Small businesses' difficulty affording insurance translates into uninsured workers and families – and disadvantages small firms in recruiting and retaining qualified employees. Firms with fewer than 50 employees offer insurance at just 46 percent of their work sites, compared with 97 percent among larger firms.³ It is therefore troubling (but not surprising) that employees of firms with fewer than 100 employees and

¹ "Study of Administrative Costs and Actuarial Values of Small Health Plans," Actuarial Research Corporation for the U.S. Small Business Administration, January 2003.

² Kaiser Family Foundation and Health Research and Education Trust, "Employer Health Benefits, 2003 Annual Survey."

³ U.S. Agency for Healthcare Research and Quality, based on the Medical Expenditure Panel Survey, Insurance Component, 2001.

their families make up about one-half of all Americans without health insurance.⁴

- **Few Options** – In most States five or fewer insurers control at least three-quarters of the small-group market.⁵ State mandated benefits further add to the cost and limit choice. Large firms can elect to self-insure – by doing so they escape state benefit mandates and other potentially costly state regulations. But small businesses are ill equipped to self-insure, lacking sufficiently large populations to pool risk and insufficient capital to assume the risk. As a result, few do.
- **Little Stability** – Small businesses' struggle to obtain and maintain insurance for their employees is also evident in the large number that begin, drop, or change coverage each year. Forty-one percent of firms with fewer than 10 employees dropped or added coverage during a recent two-year period, compared to only about 10 percent of firms with more than 100 employees.⁶ Thirty-three percent of small firms changed carriers in the past year.⁷
- **The Cost of Shopping** – On top of all this, small business owners face the daunting challenge of finding and comparing whatever insurance

⁴ Estimated for EBSA by Actuarial Research Associates, based on the Census Bureau's annual March Current Population Survey and other data.

⁵ U.S. General Accounting Office, Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage, GAO-02-8; and Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market, GAO-02-536R.

⁶ Williams, Claudia and Jason Lee (2003, September). **Are Health Insurance Premiums Higher for Small Firms**, *The Synthesis Project – Policy Brief Number 2*, Robert Wood Johnson Foundation, 4 pp.

⁷ Kaiser Family Foundation and Health Research and Education Trust, "Employer Health Benefits, 2003 Annual Survey."

products might be available. Large companies devote human resources personnel and benefits specialists or retain expert consultants to accomplish this. A small business owner typically must rely on insurance agents and devote his or her own time to the effort. In practice owners have neither sufficient time nor expertise to fully protect their interests.

In this environment it is no wonder that health insurance scam artists can find small employers who are willing to jump at what looks like a great deal – but which turns out to be, quite literally, too good to be true.

ERISA and the Regulatory Environment

To understand how scams happen, it is important to get an overview of the regulatory environment governing health benefits. With the enactment of ERISA in 1974, Congress intended to provide employers with uniform federal standards in the administration and enforcement of laws that govern and protect their employee benefit plans, including plans that offer health benefits.⁸ Thirty years later, more than 130 million Americans receive their health insurance through employer-based coverage governed by ERISA and overseen by EBSA.⁹ Under ERISA, employers may offer their workers group health plans that consist of

⁸ 29 U.S.C. § 1001, et. seq.; Section 2 of ERISA.

⁹ Estimated for EBSA by Actuarial Research Corporation.

health insurance products, which are governed by state laws and regulations.¹⁰ Each state has separate laws governing the marketing, sales, solvency, rate-setting and benefit mandates for these health insurance products. Employers may also offer group health plans that are self-funded. When an employer self-funds the health benefits for their workers, the employer's health plan will not be deemed a health insurance product, and will be solely governed by ERISA.¹¹

Employers may also obtain health coverage for their employees by purchasing through a multiple employer welfare arrangement (MEWA). MEWAs are arrangements that provide health benefits to employees of two or more unrelated employers who are not parties to collective bargaining agreements. States and the federal government coordinate the regulation of MEWAs, with the states primarily responsible for overseeing the financial soundness of MEWAs and the licensing of MEWA operators. The Department of Labor 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, which set standards requiring specified levels of reserves or contributions, are applicable to MEWAs even if they are also covered by ERISA.

¹⁰ 29 U.S.C. 1144(b)(2)(A); Section 514 (b)(2)(A) of ERISA.

¹¹ 29 U.S.C. 1144(b)(2)(B); Section 514 (b)(2)(B) of ERISA.

While many MEWAs operate successfully and provide reliable benefits, unscrupulous promoters have exploited the difficulties that small employers face in obtaining coverage to operate Ponzi schemes that collect premiums but intentionally default on benefit obligations. Fraud increases the cost for everyone, and the fear of being taken in deters many small employers from offering coverage at all.

How DOL Combats Health Insurance Scams

Because health insurance scams can operate in a variety of ways, EBSA takes a three-pronged approach to put a stop to these abusive schemes. First, we focus on prevention by educating employers and consumers. Our educational materials provide information that assists employers to recognize fraud at the outset so as not to get trapped in plans that take their money and leave their employees without coverage. Second, we take an aggressive stance on civil and criminal enforcement, working with the states and the National Association of Insurance Commissioners (NAIC) to shut down insurance scams. Third, the Bush Administration is proposing Association Health Plans (AHPs) as part of the solution to health scams because AHPs have strong protections against abuse, including a mandatory federal certification process, more uniform oversight, and strong federal solvency standards for self-funded arrangements. AHPs would

also provide small employers with good alternatives, and create more competition for MEWAs.

DOL/EBSA Prevention Efforts

Secretary Chao has released guidance to the leaders of America's small business community outlining steps they could take to avoid being taken in by promoters of insurance scams. Entitled, "How to Protect Your Employees When Purchasing Health Insurance," this simple advice provides useful tips that can help employers steer clear of coverage that is "too good to be true." Among the highlights:

- Compare insurance **coverage and costs**. Always compare the benefits and costs of multiple insurance products. If one product appears to offer similar benefits at a dramatically lower cost, ask questions.
- Confirm that the person offering the product is a **licensed insurance agent** with a proven record of reliability. Check out unknown agents with your state insurance department.
- Verify that your **state insurance department approves** any unfamiliar company, organization or product.
- Examine the policy to determine the actual coverage and whether the **promised benefits are fully insured** by a licensed insurance company.

There are several other helpful suggestions, and all of them can be found on the attached copy of Secretary Chao's guidance, and on EBSA's Web site at www.dol.gov/ebsa.

In addition, DOL has also published technical assistance materials for employers and service providers, including a booklet explaining federal and state regulation of MEWAs and guidance on what to do when health coverage can no longer pay benefits. Both the booklet and additional guidance are attached, and are available on EBSA's Web site under "Publications" or through EBSA's toll-free publications hotline at 1-866-444-EBSA (3272).

Identifying and Shutting Down Insurance Scams

Aggressive enforcement of insurance scams has long been a priority for DOL. We conduct thorough investigations, exchange relevant information with states and other agencies, file civil complaints and assist local U.S. Attorneys in bringing criminal indictments. From FY 1990 through December 2003, DOL has conducted 621 civil and 107 criminal investigations of health plans affecting 1.8 million participants and their families, and has identified violations involving \$139.5 million.

Cooperation with States and Other Agencies: EBSA and NAIC exchange case-specific information regarding ongoing MEWA investigations on a regular basis. EBSA also participates in NAIC quarterly meetings to exchange information about health issues that are of concern to government regulators. Our close working relationships with state insurance departments allow us to meet informally with them when the need arises. For instance, EBSA recently met with the New York State Insurance Department to implement procedures for EBSA to refer the names of brokers that sell unauthorized insurance products that the New York Regional Office encounters in MEWA investigations. Upon referral of the brokers, the Department of Insurance will determine whether license suspension or revocation is appropriate. We will continue to pursue these valuable cooperative relationships.

Our field offices also regularly conduct MEWA training sessions with outside agencies to discuss ongoing investigations. For example, the EBSA Atlanta Regional Office sponsored a conference for nearly a dozen regional state representatives to discuss technical issues regarding MEWAs. In August 2003, EBSA enforcement staff made presentations to over 30 supervisors of the FBI Health Care Fraud Task Force regarding fraudulent MEWAs. EBSA investigators also conducted a MEWA training session at the Federal Law Enforcement Training Center in February 2004. We undertake projects such as these on an ongoing basis in order to keep our

investigators and the outside entities we work with up to date on the latest cases and issues.

Historically, DOL has had difficulty identifying fraudulent MEWAs before problems developed and individuals were hurt. In response, DOL exercised its authority under the Health Insurance Portability and Accountability Act (HIPAA) to require annual reporting of information about MEWAs through the Form M-1. This new reporting requirement provides DOL with information about a MEWA's compliance with the requirements under Part 7 of ERISA (HIPAA), the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act (Newborns' Act) and the Women's Health and Cancer Rights Act (WHCRA). It also serves as a de facto registry of MEWAs that are attempting to comply with the law. The Form M-1 helps DOL coordinate more effectively with the States to protect small employers and their employees who may be subject to abuse by health insurance scams. The public, including State regulators, can electronically access all Form M-1s on the DOL Web site or by visiting EBSA's Public Disclosure Room.

Civil Enforcement Process: When EBSA uncovers a corrupt MEWA operation, we determine what court action is needed, and seek a Temporary Restraining Order (TRO) from a federal court to freeze the assets of both the MEWA and its promoters. The goal is to shut the scam artists down. Working closely with state

insurance departments and the NAIC, we may also ask the court to appoint independent fiduciaries to operate the plan, marshal assets for the payment of claims, and hold individuals personally liable for losses. We also share our investigative findings with the states to help them obtain “Cease and Desist” orders for cases falling under their jurisdiction.

Federal And State Cooperation In Civil Cases: As an example of our work with the states, cooperation proved crucial in the investigation of Employers Mutual LLC, a MEWA that enrolled more than 23,000 participants and beneficiaries in all 50 states. An EBSA investigation of Employers Mutual LLC disclosed that the MEWA operators transferred to themselves in the form of excessive fees, or were unable to account for, millions of dollars in plan assets rather than using those assets to pay benefits to participants. Unpaid claims for the MEWA totaled approximately \$27 million. With the help of information obtained through EBSA’s investigation, “Cease and Desist” orders were issued by the departments of insurance in Florida, Nevada, Illinois, Texas, Iowa, Washington, Pennsylvania, Massachusetts, Arizona, and Colorado. In addition, DOL obtained a temporary restraining order and a preliminary injunction and order appointing an independent fiduciary to manage the health plans operated by Employers Mutual LLC and affiliated associations. On September 10, 2003, DOL succeeded in its first step towards making workers whole when a federal court in Nevada entered a judgment requiring the principals of Employers Mutual LLC and

affiliated companies to pay \$7.3 million of the losses suffered by health plans.

Federal and State Cooperation in Criminal Cases: Criminal cases also often require the participation of many governmental entities, including, at the Federal level, DOL's Office of the Inspector General, the IRS, the Department of Justice and the FBI. For example, in *United States v. Timothy Smith*, EBSA, the Office of Inspector General, and the Georgia Department of Insurance conducted a joint investigation of a bogus health insurance product provided to more than 50 employers in Alabama and Georgia. On September 3, 2003, Timothy Smith pled guilty to embezzlement of \$217,388 and was sentenced to 40 months imprisonment, 3 years probation and was ordered to pay restitution of the amount embezzled.

Recent Cases

The following civil and criminal cases are fairly typical of the health insurance fraud schemes that DOL encounters. A few case summaries will demonstrate the types of arrangements that often defraud health plan sponsors, as well as the actions we take to recover benefits due to plans and plan participants.

Civil Cases

Mutual Employees Benefit Trust (MEBT): On November 15, 2001, DOL filed a

lawsuit against the trustees, corporations and principals affiliated with MEBT for diverting more than \$2.2 million in assets of their health and welfare plan to benefit sham labor unions and corporations. MEBT is a MEWA that provided group health and other benefits to as many as 1,900 participants. On May 4, 2002, the Court appointed an independent fiduciary to manage the plan, and on September 13, 2003, DOL obtained an order requiring the owners of MEBT to restore \$1.7 million to the plan.

U.S. Alliance, Inc. and Alliance Administrators (Alliance): On July 12, 2001, DOL obtained a restraining order freezing the assets of Alliance, which had operated numerous associations that marketed health plans to employers on the East Coast. DOL alleged that the health plan sponsored by Alliance resulted in more than \$2.8 million of unpaid medical claims for at least 1,500 participants, and that plan officials and corporate executives diverted over \$1 million of plan assets for their personal use. Following a court order freezing assets and appointing an independent fiduciary, DOL obtained a final judgment on May 16, 2003 holding the plan administrators of Alliance liable for \$2.8 million.

TRG Marketing, LLC: On October 28, 2003 DOL sued executives of TRG Marketing, LLC (TRG) for failing to prudently manage the firm's health plan, and for diverting plan assets to pay personal expenses for themselves and family members resulting in up to \$17.5 million in unpaid health claims. TRG is a

MEWA plan covering catastrophic health expenses for over 11,000 participants nationwide. DOL seeks payment of all health claims, removal of the defendants from their positions and a permanent bar to their serving as fiduciaries to any ERISA-based plan.

Provider Medical Trust: On January 30, 2004, DOL sued the fiduciaries of the Provider Medical Trust, a MEWA, for allegedly charging excessive fees and making misrepresentations that resulted in workers incurring millions of dollars in medical bills while believing they had health plan coverage. The suit seeks restitution, an accounting of plan assets, removal of the fiduciaries, and a permanent bar of the plan fiduciaries from serving on any ERISA-based plan.

Criminal Cases

United States v. Frank Rousseau: Following an investigation by EBSA and the FBI, Frank Rousseau was convicted on March 6, 2003 of wire fraud and embezzlement from a health care benefit program. He was sentenced on September 11, 2003 to 30 months imprisonment and 3 years probation. Between January and July 1997, Rousseau embezzled over \$1 million of client funds while serving as the CEO of L&H Administrators (L&H), a third party administrator hired to pay health care claims for employees. DOL is continuing to seek restitution from Rousseau.

United States v. Robert David Neal: In another criminal case the joint efforts of EBSA, the IRS and state and local agencies resulted in the indictment of Robert David Neal for health care fraud. The February 5, 2002 indictment alleged that Neal completed false and fraudulent employee applications in marketing and selling health care benefit programs in Texas and Florida. Neal pled guilty and was sentenced on August 2, 2002 to 27 months in prison, 26 months probation and restitution of \$568,042.

United States v. Pereira: Paul Pereira was sentenced March 30, 2000 to 24 months in prison, 3 years of supervised release, and ordered to make restitution of \$880,746 after pleading guilty to health care fraud and embezzlement. He established a phony insurance plan called Ameri-Med, and collected more than \$1.6 million in premiums but only paid \$360,000 in claims. The investigation by EBSA and the FBI revealed that Pereira diverted more than \$900,000 in premiums to his personal and business use.

United States v. Jerry A. Burnett: On April 23, 2002, following an investigation by EBSA and the IRS, Jerry Burnett was sentenced to 24 months imprisonment, 3 years supervised release and ordered to make restitution of \$381,052 after pleading guilty to wire fraud and making false statements on an income tax

return. Burnett operated an "employee leasing" company known as PROsera, which had over 60 clients representing almost 600 employees. PROsera agreed to establish and maintain a work-related injury and illness plan and group health insurance. Between April 1994 and December 1997, clients paid more than \$1.4 million to the employee benefit plan. Burnett failed to hold the contributions in trust and converted nearly \$250,000 of these funds to his own use.

Going Forward: EBSA Strategy and Resources

EBSA's enforcement strategy supports the Secretary's strategic goal of a secure workforce by deterring and correcting violations of ERISA with respect to health benefit programs. Finding and shutting down insurance scams is a national enforcement priority. Since President Bush took office, EBSA's investigative staff has increased by 14 percent. The President's proposed budget for FY 2005 continues this commitment, by including a request for 30 additional investigators for our regional offices, 10 of whom will be used to fill a newly created position of regional criminal coordinator. These investigative resources will further enhance EBSA's ability to address health scam issues.

AHPs - A Quality Alternative to Health Insurance Scams

I have discussed our efforts to educate small employers about how to avoid health insurance scams and our comprehensive enforcement efforts. The third

prong of our program to address health insurance fraud is to provide an alternative source of secure health insurance coverage, Association Health Plans (AHPs). Last year the House of Representatives passed the bipartisan H.R. 660, which would allow small employers to join together through *bona fide* trade and industry associations to provide health insurance coverage for their employees under the protective umbrella of ERISA and we urge the Senate to take up the legislation.

Ensuring That AHPs Keep Their Promises

This is not the forum to discuss the many advantages of AHPs, but it is important that the Committee be aware of the provisions in the legislation designed to combat fraud and prevent the type of tragic situation that occurs when fraudulent health insurance is sold. First, AHPs would be required to obtain Department of Labor certification. Only *bona fide* trade or industry associations that have been in operation for at least three years for a purpose other than offering health insurance will be allowed to sponsor such arrangements.

Furthermore, certified AHPs – both self-insured and those that purchase commercial insurance coverage – would be subject to rigorous DOL oversight. EBSA has the experience to effectively regulate AHPs. We currently have

exclusive oversight of 275,000 self-funded health plans covering 67 million individuals. ERISA's fiduciary and disclosure requirements have helped make self-funded plans strong and successful providers of health benefits to working Americans. Passage of AHP legislation would provide the same effective EBSA oversight of plans that cover small employers and their workers.

In order to be certified, a self-insured AHP would have to demonstrate that its premiums are adequate to cover its claims and operating expenses, that it has sufficient assets to ensure stability, and that it has secured backup (I.E., **STOP LOSS**) insurance to cover unexpectedly high losses. In addition, a fund will be established under DOL oversight to continue to pay stop-loss indemnity insurance premiums to cover outstanding claims in the event that an AHP becomes insolvent and unable to maintain its coverage. These three layers of protection, reserves, stop loss insurance, and the premium continuation fund will protect workers from the risk of unpaid health claims.

These provisions generally parallel the requirements that states impose on health insurers, and are vital to ensure that AHPs deliver on their promises. Finally, as a consumer protection backstop, AHP legislation would give the Secretary the authority to impose additional solvency requirements as she considers appropriate.

Taken together, these financial protections, along with EBSA's ongoing oversight, will help assure employers and employees in AHPs that their claims for benefits will be covered.

Conclusion

Health insurance scams are a real threat for small business employers and employees. Insurance failures hurt real people – workers and their families – who are seldom equipped to absorb large dollar losses. We at EBSA always remember that our job is not about abstract statistics. Our mission is to protect hard working Americans and their families. EBSA is committed to combating fraudulent health insurance schemes through education and enforcement. In addition, Association Health Plans are an important part of the solution to the problem. The Bush Administration is committed to shutting down health insurance scams and stands ready to expand access to affordable quality health insurance coverage for working Americans and their families. Thank you for the opportunity to testify today.

**Answers to Questions Posed by Sen. Charles E. Grassley -
Follow-up to March 3, 2004 Senate Finance Committee Hearing entitled
“Health Insurance Challenges: Buyer Beware”**

Question 1: You indicate that aggressive enforcement of insurance scams has long been a priority for DOL and note that from FY 1990 through December 2003, DOL has conducted 621 civil and 107 criminal investigations. What has been the outcome of those investigations – how many scams were actually shut down? How many operators of these scams ceased further operations vs. launched other bogus insurance ventures? What funds and assets were reclaimed? Have any perpetrators of these scams been convicted and sent to jail?

Answer: The statistics we have provided you relate to investigations that are part of our Multiple Employer Welfare Arrangement (MEWA) Project. We have found a variety of violations of the Employee Retirement Income Security Act of 1974 (ERISA) in these cases, such as the payment of inappropriate expenses, in particular excessive management fees; the diversion of assets for the benefit of the MEWA operators; the failure to charge adequate premiums in order to meet benefit obligations; and misrepresentations regarding the financial condition of the MEWA. EBSA maintains a “Watch List” of individuals who have been involved in prior MEWA investigations, which it shares on a quarterly basis with the National Association of Insurance Commissioners.

Civil Investigations: Our primary objective in civil investigations of fraudulent MEWAs is to shut down these abusive operations and recover as much money as possible for the victims of these scams. We conducted 621 civil investigations in connection with the MEWA Project during the period; 503 have been closed. Of these closed investigations, 246 achieved corrections of ERISA violations. One hundred and sixty-five resulted in approximately \$137 million of monetary results on behalf of the victims; 57 resulted in other non-monetary fiduciary violations corrections, including 147 fiduciaries removed or enjoined from serving as fiduciaries to ERISA-covered plans; and 24 non-fiduciary violations corrected, including the resolution of reporting, disclosure or bonding issues.

Criminal Investigations: Of 107 investigations in connection with the MEWA Project, 87 indictments were handed down in 40 different investigations. Of those 87 indictments, 72 individuals either pleaded guilty or were convicted of criminal violations. Of the remaining individuals, 5 were acquitted, 5 indictments were dismissed, 3 individuals are pending trial, and 2 are fugitives from justice.

Question 2. You state that since President Bush took office, EBSA’s investigative staff increased 14 percent and that the FY 2005 proposed budget continues this commitment by including a request for 30 additional investigators for regional offices, 10 for newly created regional criminal coordinators positions. What is the size and composition of EBSA’s investigative staff at present, and how are they distributed between Washington and the regional offices? How many FTE staff are

dedicated to detecting and preventing this type of insurance fraud as opposed to providing oversight for single-employer ERISA plans.

Answer: EBSA's FY 2004 budget requested 930 FTE; of this 645 were allocated to the field and 285 for the national office.¹ In FY 2005, the President is requesting 30 additional investigative staff, 10 of which will be devoted to criminal investigations at the field level. The criminal arena is often the only method for punishing corrupt MEWA operators who have squandered the money that was improperly taken from innocent participants and beneficiaries. Part of the function of these new positions will be to see that these individuals are brought to justice. The following table depicts the growth from the FY 2000 budget and the commitment to increasing enforcement.

Fiscal year	National Office	Field Office	Total
2000	261	562	823
2001	275	575	850
2002	275	575	850
2003	276	585	861
2004	285	645	930

As of May 1, 2004, EBSA had on board 434 staff involved in either investigations or the supervision of investigations in the field. In addition, EBSA has 93 benefit advisors in our field offices who play an important role in fraud prevention by answering questions and hearing complaints from workers about their employee benefit plans. Every complaint our benefit advisors receive is responded to, and these complaints often lead to investigations by our enforcement staff. The remaining positions in our field offices consist of 44 clerical, and 14 program support positions. In addition to the field staff involved in investigations there are approximately 26 FTE in the National Office of Enforcement involved in providing technical assistance and policy oversight for on-going investigations. While certain DOL staff have developed particular expertise in the MEWA area, all EBSA investigators are available to handle any type of investigation involving violations of ERISA.

The Office of Enforcement has a National MEWA coordinator who provides policy and investigative oversight for the MEWA cases being investigated by EBSA field offices. The coordinator prepares a number of reports on a quarterly basis for review by senior EBSA National and field management. These reports include a detailed summary of all open MEWA cases; a special report to senior level EBSA management on the most significant MEWA cases; and a watch list of individuals involved in prior MEWA investigations. The national MEWA coordinator works with the designated MEWA coordinator in each regional office who is responsible for oversight of the MEWA cases being worked in his/her region.

Question 3. The GAO reports that states issued 108 cease and desist orders that affected 41 of the 144 entities covering 58 percent of the policyholders and nearly half of the claims while DOL issued temporary restraining orders or injunctions

¹ The amount of appropriated funds was not adequate to fund the cost of 30 FTE.

against only 3 entities that affected 13 percent of the policyholders and 15 percent of the claims. Why did DOL take action against only 3 entities? What specific factors limited your ability to halt so many of these unauthorized health plans? What factors enabled the states to respond more quickly and broadly?

Answer: States have the authority to issue cease and desist orders to stop an entity's activities if they believe violations of state insurance law have occurred. Although the DOL does not have the authority to issue cease and desist orders, it too can shut down an entity's operations by going to court to obtain a temporary restraining order based upon violations of ERISA.

The most important difference between the state insurance proceedings and the DOL's actions in federal court is the type of proof necessary to shut down the illegal operations. In many cases, a state can obtain a cease and desist order merely by showing that the entity did not have a license to sell insurance. In contrast, the DOL has to prove that the entity has mismanaged or stolen plan assets, or engaged in other types of fiduciary misconduct. As a result, before the DOL can prove a violation, it typically must obtain bank records, receipts, and claim records from entities that are often actively trying to conceal their financial activities. From these often incomplete or incorrect records, as well as numerous interviews, the DOL generally has to trace the flow of plan assets, analyze the propriety of disbursements, and prove fiduciary misconduct. It is not enough to show that claims are unpaid or that there is an apparent risk that the entity will fail; the DOL must be able to show a specific fiduciary breach.

As a result of these differences between the state and federal legal regimes, the DOL and state regulators actively work together during the investigative stages of a MEWA case in order to provide mutual support to utilize the most timely and efficient enforcement tools available to help stop health insurance scams. In many instances, the states' use of cease and desist orders based on state-law standards is a more timely means of shutting down illegal operations in particular states, while the DOL prepares an ERISA action which covers the defendants' actions nationwide.

Question 4. In his testimony, Mr. Nepple, representing NAIC, notes that most unauthorized health plans discussed in the GAO Report have two factors in common: they claim to offer a plan subject to ERISA, and they, therefore, claim to be exempt from state insurance regulation. Since this is now the country's third round of insurance scams, why have the states and the DOL not been able to develop statutes and regulations that would address the legal gaps that allow these scams to continue? Other than supporting national AHP's, has DOL undertaken legislative or regulatory initiatives that would address current ERISA deficiencies? If so, briefly describe them.

Answer: We would be happy to work with Congress as it explores additional statutory enforcement tools to further aid the DOL in its efforts under ERISA to combat health insurance fraud. EBSA recognizes that it shares jurisdiction with the states over the

regulation of MEWAs, and aggressive MEWA enforcement has long been a priority of the DOL.

As part of this ongoing effort, states and the federal government coordinate the regulation of unauthorized insurance entities (including MEWAs) pursuant to the 1983 statutory amendment to ERISA that made it clear that states are free to regulate MEWAs whether or not the MEWA is an ERISA-covered employee welfare benefit plan. In this regard, state insurance laws that set standards requiring specified levels of reserves or contributions are applicable to MEWAs even if they are also covered by ERISA.

With regard to our regulatory initiatives, in April 2003, the DOL promulgated a final regulation under section 3(40) of ERISA. The regulation assists labor organizations, plan sponsors and state insurance departments in determining whether a plan is a multiple employer welfare arrangement within the meaning of section 3(40) of ERISA.

In addition, in February of 2000, DOL implemented a new requirement that MEWAs register with the Secretary of Labor annually. This reporting requirement was authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). MEWAs register by completing a Form M-1 and DOL has established a help desk to assist MEWA administrators. Data gathered from these M-1 filings represents the only national registry of MEWAs operating throughout the United States. In 2003, DOL made an electronic database of Form M-1 filer data available to state regulators, other federal regulators, and the public, so that this information could be accessed and shared more efficiently. Subsequently, in February of 2004, DOL made available a new, voluntary online filing feature to make it easier for MEWA administrators to file the Form M-1.

We are currently in the process of examining additional changes to ERISA, beyond those incorporated in the AHP legislation, that are necessary. In this regard, we are reviewing the recommendations of Insurance Commissioner Montemayor and the National Association of Insurance Commissioners concerning the development of additional anti-fraud legislative proposals. We are ready to work with you and other Members of the Committee to develop the strongest possible anti-fraud provisions to help protect American workers and their families.

Question 5. Mr. Montemayor and Ms. Kofman both recommend giving DOL cease and desist authority to enhance DOL's enforcement capacity. What is your view on this recommendation? How would such authority impact the staff resources EBSA would require to more effectively identify, enforce against and deter health insurance scams?

Answer: As indicated in the response to Question #4 above, we are currently in the process of examining these issues and reviewing the recommendations of Insurance Commissioner Montemayor and the National Association of Insurance Commissioners concerning the development of additional anti-fraud proposals, including broad federal administrative cease and desist authority. The current AHP legislation passed by the House and pending before the Senate includes provisions that would create federal cease

and desist authority for the Department of Labor, and we strongly support this legislation. At this time, it is premature to assess the resource allocations cease and desist authority would have on EBSA since the allocations would largely depend on the nature and scope of such authority.

Question 6. We understand from conversations with the DOL, that there are several new target areas for these insurance scam artists; they are Atlanta, Georgia, New York, New Jersey and Washington State. Are you doing anything special to address that fact in those four areas?

Answer: For the last two years, our Atlanta Regional Office (ARO) has conducted bi-annual meetings with all insurance departments for the states in its jurisdiction. On occasion, representatives from surrounding states have attended, as well as Assistant United States Attorneys (AUSAs). The meetings address problem cases being worked by the ARO and suspect entities in ARO's jurisdiction.

The New York Regional Office (NYRO) has actively engaged in coordination efforts with both states within its jurisdiction, New York and New Jersey. The NYRO has developed strong relationships with state insurance officials and the agencies meet periodically to discuss issues of mutual interest. Specifically, during FY 2003, the NYRO met with the New York State Attorney General's Office to address MEWAs and the abusive conduct of insurance brokers and others involved in health insurance abuse. The NYRO agreed to notify the Insurance Department of any brokers that were associated with unscrupulous MEWAs and a referral tracking form was prepared.

On March 11 and 12, 2004, the New York and Philadelphia Regional Offices sponsored a Regional Multiple Employer Welfare Arrangements Conference in Trenton, New Jersey. The conference was attended by seventy-five participants and included representatives from the state insurance departments of New Jersey, New York, Pennsylvania, Maryland, Delaware and the District of Columbia. Staff members from the Pennsylvania and New Jersey Attorney General's Offices were also in attendance. The DOL Office of Inspector General was represented and sent staff members from all offices within the New York and Philadelphia regions. The FBI sent agents from the Health Care Task Force. Also in attendance were local prosecutors, the Postal Inspection Service and EBSA investigators from the Boston, New York and Philadelphia regions.

With respect to MEWAs in Washington State, our San Francisco Regional Office, through the Seattle District Office (SDO), has a MEWA coordinator actively participating on a longstanding Health Care Fraud Task Force with members of the National Association of Insurance Commissioners (NAIC). As a member, the MEWA coordinator receives the group mailings of the NAIC members who identify, discuss, and request information about various MEWA operators in the Northwest (and nationwide).

The SDO has initiated efforts to create a Northwest MEWA Task Force, to include Washington State. The office is also coordinating open investigations with the

Washington State Insurance Commissioner and is providing outreach to the public at large regarding health benefits.

Question 7. Would you please briefly tell me about the loopholes in the law that these entities are taking advantage of to slip through the cracks and tell me what needs to be done to close these loopholes?

Answer: Although Congress amended ERISA in 1983 to clarify that the States have jurisdiction over MEWAs, MEWA promoters continue to create confusion and uncertainty as to the ability of States to regulate MEWAs by claiming ERISA coverage and Federal preemption of state law.

For example, in recent years some promoters have claimed to be collectively bargained plans because such plans are excluded from the statutory definition of MEWAs. To address this, in April 2003, the DOL promulgated a final regulation that assists labor organizations, plan sponsors and state insurance departments in determining whether a plan is a legitimate collectively bargained plan or a MEWA within the meaning of section 3(40) of ERISA.

Other MEWA promoters have marketed their health benefit programs under the guise of professional employer organizations or employee leasing companies and claimed that the program was a single-employer plan, not a MEWA. A third scenario, which has begun to emerge, is one where a MEWA promoter claims it is not marketing unlicensed insurance but merely is a third party administrator providing administrative services to separate single employer plans of its client employers.

The best way to close these “loopholes” is to provide a clear alternative in the marketplace – federally certified and regulated Association Health Plans (AHPs). Federal certification, required before an AHP could offer benefits to a single worker, would provide consumers with the assurance that the Department of Labor has determined that the organization offering coverage is a financially secure and reliable operation. If an insurance seller is neither licensed by a State nor certified as an AHP, consumers would be well advised to exercise caution.

In addition, the Department is committed to continuing and improving its vigorous enforcement activity and close coordination with the states to shut down illegal health benefit schemes and to recover funds for victims. The Department also will continue to emphasize education and outreach to employers to prevent them and their workers from falling victim to fraudulent health benefit scams.

Question 8. It seems that timely information is one of the keys to success at stopping these scam artists. Is it possible for DOL to post open cases on its website to get timely information to insurance agents and consumers?

Answer: The established method of providing information to insurance agents is through the various state insurance commissioners. EBSA works in conjunction with

commissioners of insurance in order to exchange the latest information on these plans. In addition, EBSA's Customer Service Units in the National and Regional Offices gather information from the public and the health plan industry. This information often turns into a lead, which is referred for investigation. EBSA has jointly worked cases during the investigative stage with state regulators and in those cases investigative information is shared. A prominent example of this was the investigation of Employers Mutual LLC, a MEWA that provided health benefits to more than 23,000 participants and beneficiaries in all 50 states. As a result of this cooperation, cease and desist orders were issued in ten different states concurrently with the Federal investigation.

As is the case with other enforcement agencies, EBSA's policy is neither to confirm nor deny the existence of an investigation, unless special circumstances warrant otherwise. Whether an investigation is underway, or is contemplated, is usually not discussed with the public. EBSA adopted this policy to protect entities that may have been the subject of an investigation, but are later found not to be in violation, and to encourage restoration of plan losses through voluntary compliance. Once an action has been initiated in federal court, either civilly or criminally, EBSA immediately issues a press release announcing that fact. These press releases are promptly posted on EBSA's website.

Question 9. In light of the fact that the life of an insurance scam is relatively short, does the DOL currently possess cease and desist order authority? Does DOL need more administrative authority to act quicker and shut these scams down?

Answer: As noted in our response to Question #3, DOL does not currently have the authority to issue cease and desist orders. However, we do coordinate closely with our counterparts in the various state insurance departments and share relevant information with them to enhance their ability to exercise cease and desist authority in conjunction with our enforcement efforts.

In addition, as mentioned previously, we are currently in the process of examining these issues and reviewing the recommendations of Insurance Commissioner Montemayor and the National Association of Insurance Commissioners, including their recommendation that the DOL have broad federal administrative cease and desist authority as part of any additional anti-fraud proposals put forth by Congress. The current AHP legislation passed by the House and pending before the Senate includes provisions that would create Federal cease and desist authority for the Department of Labor, and we strongly support this legislation. We are ready to work with you and other Members of the Committee to explore the development of further anti-fraud provisions to help protect American workers and their families from health insurance scams.

10. On average, how many resources does DOL use to investigate companies selling health insurance on the Internet? Does DOL actively search and investigate various Internet sites marketing health insurance? Has DOL identified any bogus health plans through Internet searches?

Answer: DOL does not generally target investigations on health insurance companies advertising on the Internet because this would not be a prudent use of our resources. Many alternative or low cost health plans advertised on the Internet are neither insurance nor MEWAs; they are "discount plans," i.e., groups of doctors and other providers who agree to discount their prices. Such plans generally are not covered by ERISA or state insurance law, as noted in the GAO report released at the March 3, 2004 hearing (GAO-04-312, "Private Health Insurance: Employers and Individuals Are Vulnerable to Unauthorized or Bogus Entities Selling Coverage"). According to the report, "[w]hile discount plans are not problematic as long as purchasers clearly understand the plans, 14 states reported that some discount plans were marketed as health insurance with terms or phrases such as "medical plan," "health benefits," or "pre-existing conditions immediately accepted." Because neither EBSA nor State insurance commissioners would have jurisdiction, the GAO report says that consumer complaints about such plans may be referred to a State's attorney general.

Question 11. We have seen many scam artists consider civil judgments to be a cost of doing business. More aggressive actions need to be taken against these scam artists to deter them from engaging in this type of business. How many plan operators have been prosecuted under federal law over the past three years? Why are there not more criminal actions taken against these operators?

Answer: The prosecutorial discretion regarding whether the federal government will bring a particular MEWA case currently lies within the Department of Justice (DOJ). We coordinate closely with DOJ at the national level and with the local US Attorneys. As a result, we are seeing an increased interest among US Attorneys in pursuing health insurance fraud.

In the past three years there have been 20 indictments resulting thus far in seven guilty pleas in MEWA cases. The investigation and prosecution of these types of cases are both time intensive and complex. For example, in one recently indicted case our investigators spent nearly two years of investigative time conducting the investigation that led to several indictments. The perpetrators of these schemes change states and corporate identities making it difficult for investigators to track their schemes. They mask their fraud by claiming federal regulation with no state regulation or oversight. In some cases, the perpetrators attempt to legitimize their operations by obtaining legal advice that can be misconstrued by the reader. The perpetrators adapt schemes to take advantage of new regulations or opportunities in the market.

These cases are not run of the mill insurance fraud but complex Ponzi schemes that require investigative diligence and perseverance. In some cases EBSA's investigations find that money paid for premiums had been deposited in foreign bank accounts and in other cases paid to bogus offshore insurance companies.

Although the cases provide challenges, let me assure you that health coverage scams are a top enforcement priority, and we will continue to pursue them until these unscrupulous operators are stamped out. Our commitment is to protect American workers and their

families, and to ensure that they do not fall victim to fraud. In addition to our enforcement efforts, we are working to prevent people from being taken advantage of by educating consumers how to avoid scams and by providing a secure and well-regulated alternative in the form of Association Health Plans. We would be happy to work with Congress as it explores additional statutory enforcement tools to further aid the DOL in its efforts under ERISA to combat health insurance fraud.

Question 12. If a consumer would like to know whether a health plan is indeed exempt from state regulation under ERISA, where could they call at the Department of Labor? Is there a way to create a “bright line” test so consumers can know whether a health plan is truly exempt from state regulation or a fraudulent plan?

Answer: Consumers may contact EBSA by calling 1.866.444.EBSA (3272) or by visiting our website at www.dol.gov/ebsa. Our benefit advisors are available to answer employee benefit questions, including questions about health coverage, and the website provides a list of steps to take to avoid being taken by fraudulent health scams.

The structure of ERISA, however, makes it difficult to establish a useful, consumer-friendly test for discriminating between fraudulent health arrangements and those legitimately exempt from State regulation. The Act's necessarily broad definition of employee benefit plan overlaps with arrangements subject to State insurance regulation. Congress addressed foreseeable conflicts by expressly saving State insurance laws from the general preemption of State laws that relate to ERISA plans while, at the same time, prohibiting States from treating these plans as insurance companies.

ERISA allows the States to regulate health benefits provided through insurance contracts, but frees employers who self-fund their benefits from the strictures placed on commercial insurers. For single employer health and for collectively bargained multiemployer plans, this choice of regulatory schemes serves employees well. However, unscrupulous entrepreneurs seek to exploit the overlap between state and Federal regulation for criminal gain.

In 1983, Congress addressed this problem by passing legislation allowing States to regulate non-collectively bargained health benefit arrangements for employees of multiple employers, even if the arrangement is an ERISA plan. Although this measure discouraged some abusive arrangements, it did not fully solve the problem. Moreover, some vendors of fraudulent health coverage concocted sham collective bargaining agreements to confuse State regulators. To help the States frustrate these schemes, the Department last year issued a regulation providing for expeditious determinations of the bona fides of collective bargaining agreements in this context.

Question 13. To what extent are the Department's efforts in investigating and taking enforcement action regarding these entities centrally directed or left to the discretion of the regional Employee Benefits Security Administration (EBSA) offices?

Answer: Each EBSA office is required to use its investigative resources in accordance with the criteria established in EBSA's nationally designed enforcement strategy. For FY2004, the Assistant Secretary identified MEWAs as one of five areas in which EBSA should place enforcement priority. Each regional office has a MEWA coordinator who reports to the National MEWA coordinator in the Office of Enforcement. As indicated previously, the MEWA coordinator prepares policy and investigative oversight for the MEWA cases.

Question 14: As I understand it, the Department of Labor (DOL) now requires "MEWAs" to submit M-1 filings to register with the DOL. Has DOL reviewed these filings to determine if MEWAs are in compliance with federal requirements? If so, could you please describe the nature and frequency of any review? What steps, if any, is DOL taking to enforce the law where MEWAs have failed to submit the M-1 or have provided incomplete information? Has DOL used its authority to impose fines for inadequate filings?

Answer: As noted earlier, in February of 2000, DOL implemented a new requirement that MEWAs register with the Secretary of Labor annually. This reporting requirement was authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). MEWAs register by completing a Form M-1 and DOL has established a help desk to assist MEWA administrators.

Data gathered from these filings represents the only national registry of MEWAs operating throughout the United States. In 2003, DOL made an electronic database of Form M-1 filer data available to state regulators, other federal regulators, and the public, so that this information could be accessed and shared more efficiently. Subsequently, in February of 2004, DOL made available a new, voluntary online filing feature to make it easier for MEWA administrators to file the Form M-1.

Since implementing the statutory requirement, DOL's primary goal has been to "get MEWAs on our radar screen" by obtaining Form M-1 filings from MEWA administrators. To that end, EBSA focused on educating the public about the Form M-1 filing requirement and, where necessary, pursuing civil enforcement actions against MEWA administrators who failed to file.

However, the type of information that is requested on the Form M-1 is limited. This is due to the fact that the statutory authorization under HIPAA only requires MEWAs to report about their compliance with the health coverage requirements of Part 7 of ERISA (*i.e.* HIPAA, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act). The statute does not authorize DOL to require the filing of any financial information concerning the filing entity. Accordingly, the Form M-1 is a limited tool in identifying financially unsound and potentially fraudulent MEWAs.

DOL currently reviews Form M-1 filings on an ongoing basis to determine whether the filing entity is in compliance with Part 7 of ERISA. For filings that indicate non-compliance with Part 7 of ERISA, a referral to the relevant EBSA field office is made for further investigation. In addition to reviews to determine noncompliance, many of the Form M-1 non-filer cases originate from EBSA's investigations of MEWA administrators. DOL also performs analyses of multiple years' Form M-1 databases to identify MEWA administrators who unexpectedly stopped filing. As a result of this analysis, the DOL obtained over 110 Form M-1 filings during fiscal year 2003 from administrators who would otherwise not have filed. During fiscal year 2004, DOL is reviewing the Form M-1 database for filings that fail to report significant information required by statute. We will contact these filers in writing to request they amend their filings, and take appropriate action for continued noncompliance.

Concerning fines, few penalties have been assessed against MEWA administrators for delinquent Form M-1s because 1) many delinquent filers are bankrupt, and 2) many administrators are not subject to penalties due to a statutory exception.

Question 15: In your testimony, you spoke positively about proposals to allow federally-regulated Association Health Plans (AHPs) to operate in the small group market. As I understand it, AHPs would be different from the self-funded plans DOL typically regulates. While an employer pays health care costs for employees out of its own revenues, a self-funded AHP will collect premiums from multiple small employers, assume risk, and pay claims – essentially functioning like an insurance company. Does DOL have experience in regulating financial solvency, marketing standards, and premium levels for health insurers? If so, could you please explain in what context(s) DOL has engaged in this form of regulatory activity?

Answer: Under the proposed legislation, the Department would certify that an AHP meets the stringent requirements of the law, including solvency standards, before the AHP offered benefits to a single worker. It is important to note that the legislation provides for both insured and self-funded AHPs and that these are regulated differently.

Insured AHPs would offer state-licensed and regulated insurance products that would be required to comply with state consumer protection laws, including solvency requirements. Thus, the state insurance regulatory agencies will retain their responsibility for administering these provisions under their own laws. We anticipate that the great majority of AHPs will be insured and thus subject to this state regulation.

Self-funded AHPs would operate in a manner similar to union multiemployer health benefit plans, which are exclusively regulated by the Department of Labor. In these plans, a number of different employers provide health benefits to workers pursuant to a collective bargaining agreement. Such arrangements are common in the building trades and other industries where union members tend to work for different and often small employers. In these arrangements, which are widely regarded as providing secure and generous benefit packages, the employers contribute to the plan on behalf of the

employees who are members of the union, and the plan uses these contributions to provide health benefits. Similarly, a self-funded AHP would collect contributions from employers who are members of the association and use these funds to pay benefits. In addition, the AHP legislation imposes new and additional solvency requirements on self-funded AHPs that go far beyond any current law protections for union multiemployer health benefit plans. The legislation requires self-funded AHPs to maintain an actuarially certified cash reserve, to maintain an additional cash reserve of up to two million dollars, to purchase both aggregate and specific stop loss insurance, to purchase indemnification insurance to ensure that claims will be paid if the plan does terminate, and establishes a fund administered by the Department from fees charged to AHPs that can be used to pay for stop loss and indemnification insurance.

As noted above in the answers to questions 1, 2 and 6, the Department has a vigorous enforcement program to prevent health fraud. Separate from these enforcement activities, the Department has been building an infrastructure in the health area for several years in response to the enactment of health legislation that amended ERISA and gave the Department significantly more responsibility and oversight in the health coverage arena. This infrastructure was put in place in response to the enactment of the Health Insurance Portability and Accountability Act of 1996, the Mental Health Parity Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998. The Department also has interpretive and regulatory authority over the disclosure and notification requirements of COBRA.

We should note that the Department already performs functions similar to many of those performed by state insurance departments, such as assisting participants with questions about their rights under their health benefit plans and relevant laws. While the AHP legislation does require the Department to perform some new functions, particularly in connection with the additional protections the legislation puts into place for self-funded AHPs, the Department will not certify a self-funded AHP, allowing it to begin offering benefits, until we have made certain that our regulatory structure is capable of protecting workers and their families in these plans.



U.S. SENATE COMMITTEE ON

Finance

SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN

<http://finance.senate.gov>

Opening Statement of Sen. Chuck Grassley
Hearing, "Health Insurance Challenges: Buyer Beware"
Wednesday, March 3, 2004

Good morning. I thank everybody for coming. This hearing has three purposes: (1) Expose the significant and growing problem of unauthorized and bogus health plans and their damaging effects; (2) Educate people, including employers, about unauthorized and bogus health plans – what they look like; (3) Empower people with information – how not to fall prey to one and if you've already been scammed, what to do next. There is much to be done at the state level, at the federal level, and by the insurance industry among others. Good faith efforts have been made, and I commend the efforts made by DOL, NAIC and the states. But, at the same time, we can and must do much more to protect everyday people from becoming victims. In other words, we need to stop bogus health insurance scams. The problem is growing. The GAO reports that from 2000 through 2002, more than 200,000 policyholders were taken by bogus health insurance scams.

An unauthorized health insurance and a bogus health insurance plan are entities that sell health insurance to individuals, unions, associations and others with the intent not to pay claims. This is not a new phenomenon but a continuously growing one. Here's what I'm talking about. This is a pamphlet that was distributed by one of these phony health insurance plans. It's shiny and glossy and paints a pretty picture. In addition, my staff recently received this piece of literature advertising health insurance at an extremely low cost. This plan is even advertising that it will accept people with all pre-existing conditions. This came across a committee fax machine last week. To the average person these look like fabulous opportunities to get lots of health coverage and other benefits at low prices. Unfortunately, these items are from phony insurance companies.

The proliferation of the Internet, the increasing number of the uninsured and the ever-increasing costs of healthcare make the perfect breeding ground for these scams to be born and grow. This hearing is a wake-up call to America, and a reminder that there are unscrupulous individuals who intentionally inflict emotional and financial harm upon businesses and individuals. We must focus on awareness, education and aggressive oversight to prevent bogus plans from taking people's hard-earned money. Today, 43 million Americans are desperate for affordable health insurance coverage. In addition, the number of people covered by government health insurance programs is on the rise. With more and more people being taken by these bogus health plans, the system is being pressured. More and more people will become uninsured and end up on federal assistance programs.

Let us not forget that there are also tax and other health policy implications. The predators are defrauding the IRS, the victims are taking deductions and when all is said and done, some victims may very well join the ranks of Medicaid. We also need to target the scam artists, who do a disservice to all the good insurance companies out there.

On a personal note, I want to point out that no insurance company is safe from bogus health plans. Employers Mutual LLC, a scoundrel that scammed thousands of people, took its name from a reputable Iowa insurer, Employers Mutual Casualty Company, that has been in business for more than 90 years. The real Employers Mutual has received more than 75 complaints from people confusing it with Employers Mutual the scam. By using the name of a reputable company, bogus plans aim to confuse consumers, take their money and run.

Any person taken by a bogus plan is one victim too many. It is easy to forget that there are human lives and untold stories behind the statistics. That is why we will hear this morning from a panel of everyday Americans, dealing with the horrible consequences of bogus health plans. They will tell us very troubling and all too common stories. Each has come before this Committee to remind us that no one is safe from the wrath an unauthorized health plan can leave behind.

At my request, along with the requests of Senators Bond and Snowe, the General Accounting Office has issued a "fact" report assessing the effects of unauthorized health plans. I welcome Ms. Kathryn Allen who will testify about the latest GAO report. The GAO report is a fact report. It is the first step at looking at this complex problem. Also, GAO's Office of Special Investigations will discuss its investigation of Employers Mutual LLC's operations. DOL Assistant Secretary Ann Combs is with us, too. DOL's responsibility of enforcing the federal requirements for insurance and group health plans found in ERISA and implementing initiatives to combat this growing problem is of paramount importance. We welcome testimony from the National Association of Insurance Commissioners. Also, the Texas Department of Insurance will discuss efforts to educate consumers and aggressively pursue bogus plans. Finally, we will hear testimony from Mila Kofman about her work in this very important area.

Now, I would like to say what this hearing is not about. This hearing is not about "association health plans," as some have asked me and members of my staff. Legislation creating these types of plans is not before this committee, and we have no jurisdiction over their implementation. Instead, this hearing is about predators – predators who are feeding on everyday citizens across the nation. I want to close by saying that it is extremely important and valuable to maintain a dialogue among the insurance industry, regulatory agencies, Congress and consumers about the problems that persist. I hope this hearing will help continue and expand that dialogue and provide a road map for what still needs to be done. We need to "stop the bleeding" now.

Closing Statement of Sen. Chuck Grassley
 "Health Insurance Challenges: Buyer Beware"
 Wednesday, March 3, 2004

That brings us to the end of our hearing today. First of all, I thank all of the witnesses for taking the time out of your busy schedules to come and help us do this important work here today.

We owe a special word of thanks to Ms. Almond and Ms. Piantadosi, who were willing to share the tragedy they are still living. Once again I think it is important, first and foremost, to make sure that there is a continued and sustained federal and state effort to follow through and address the problems we have heard about today. It is time to stop being reactive. We must be more proactive at shutting down these bogus plans before more citizens are financially and emotionally harmed.

Coming out of this hearing, I see that we have the federal government, the states and the NAIC working together cooperatively and in good faith to attack this behemoth. At the same time, I see that: (1) not everyone who should be active is; (2) those working together do not share the same overall authority; and (3) there is no consistent, national comprehensive strategy for a systemic nationwide problem. So here is what I propose: At the conclusion of this hearing, I intend to contact the American Medical Association and the American Hospital Association, which are also on the front lines of the damages that bogus health insurance scams can cause. They, too, with the small business community, including the National Federation of Independent Business and Women Impacting Public Policy, can get the word out and help identify a problem early and equip their membership with the tools to avoid the problem or the payer avenues to take if they've been victimized.

I am also going to formally request that the GAO evaluate the effectiveness of current coordination efforts among and between the states, NAIC and the federal government. Also, I am going to ask that the GAO assess the effectiveness of DOL oversight of employer-sponsored health benefits in general, or problematic/scam plans in particular, including the consistency and effectiveness of efforts across DOL regions. In addition and perhaps most importantly because there is "no silver bullet" to this problem, I am directing my staff to work with DOL and other relevant committee staff to see if we can tighten up ERISA and to examine the civil, criminal and administrative remedies available to the DOL to see if some improvements can be made to address this problem once and for all.

Early detection, aggressive oversight and effective communication are the keys to success in addressing bogus health insurance scams. Getting valuable information to the citizens across this nation, along with continued communication between state and federal governments, can only lead to the downfall of more and more of these scam artists, and that is my goal.

Panel I – Introduction:

I thank each of my colleagues for their statements and being here today. On our first panel of the day I welcome two individuals who have experienced first-hand the devastating consequences of unauthorized health insurance plans. I am thankful that these two women, who have both endured horrific experiences, are here today to share their stories. I welcome Marie Almond and Joan Piantadosi [PE-ANTA-DOE-SEE] before the Committee.

Our first panelist, Ms. Almond, traveled from Albemarle, North Carolina to be here with us. She will testify about her experience with Employers Mutual LLC, an unauthorized health insurance plan. Our second panelist, Ms. [PE-ANTA-DOE-SEE], traveled here from Deerfield Beach, Florida. She will also testify about her family's experience with Employers Mutual LLC. Her husband, Albert Piantadosi [PE-ANTA-DOE-SEE], suffered from end stage liver failure and was in need of a liver transplant. He was lucky enough to have the support of his community and able to get a liver

transplant. Unfortunately, Mr. Piantadosi [PE-ANTA-DOE-SEE] cannot be here with us today due to health reasons.

Both of these women are here today under trying circumstances because they want to share their horrific experiences with health insurance fraud. In doing so, they hope to prevent other families from suffering the consequences of bogus health insurance plans.

Ms. Almond – we will start with you.

[ALMOND Testimony]

Thank you, Ms. Almond.

Ms. Piantadosi [PE-ANTA-DOE-SEE] – would you begin please.

Panel II – Introduction:

On our next panel, we will hear from the GAO's Kathryn Allen, who is Director of Health Care in Medicaid and Private Health Insurance Issues. She will be followed by Mr. Robert Cramer, who is Managing Director for the GAO's Office of Special Investigations. Following Mr. Cramer will be Ms. Ann Combs, DOL's Assistant Secretary.

Ms. Allen will testify about the latest GAO report, that I requested along with Senators Bond and Snowe, to assess the effects unauthorized health benefit plans had on employers and individuals who fell victim to these scams. I look forward to hearing about where we stand today. As always, I think it's fair to say that on both sides of the aisle we are thankful for the leadership of Ms. Allen in this important field.

[ALLEN TESTIMONY]

Next I welcome Mr. Cramer to the fold today. I look forward to hearing from him today about the OSI's most

recent findings in this area as well.

[CRAMER TESTIMONY]

Next we have the good fortune to have DOL Assistant Secretary Ann Combs with us today. Ms. Combs holds the significant responsibility of administering and enforcing Title I of ERISA. I thank her for appearing before the Committee – it is an important role as Assistant Secretary to testify about what is going right and what is going wrong at DOL. I know she will testify about the strides DOL has made to improve education and enforcement efforts and about the great strides that still need to be taken to combat these bogus health plans. I expect that DOL will continue to address the Committee's concerns and take action to improve this situation across the nation. Welcome, Assistant Secretary Combs, you may begin.

[COMBS TESTIMONY]

Thank you Ms. Combs.

Panel III – Introduction:

Finally, we begin our final panel of the day with Mr. Fred Nepple, who chairs the NAIC's ERISA Working Group. He will be followed by Mr. Jose Montemayor [MONT-E-MA-YER], who is the Commissioner of Insurance in the State of Texas. Ms. Mila Kofman will be our last witness. Ms. Kofman is an Assistant Research Professor at Georgetown University.

Mr. Nepple will testify about the latest efforts the NAIC has taken to educate its members about unauthorized health insurance plans. I think it's fair to say that NAIC plays a critical role in educating consumers and businesses across the nation. I look forward to hearing about the many campaigns and education tools NAIC has developed.

[NEPPLE TESTIMONY]

Next I welcome Mr. Montemayor [MONT-E-MA-YER] here today. Thank you for traveling to Washington all the way from Texas. I look forward to hearing about the efforts

Texas has taken to combat this ever-growing insurance problem.

[MONTEMAYOR TESTIMONY]

Finally, I welcome Ms. Kofman. Ms. Kofman has written recent studies on the phony insurance problem facing the nation today. I look forward to hearing about the results and recommendations of your work.

[KOFMAN TESTIMONY]

Thank you Ms. Kofman.

**Senator Grassley's Seven Tips
to Avoid Being a Victim of a Health Insurance Scam**

1. **Before You Buy, Verify.** Contact your state insurance department and the Department of Labor to verify that the plan is licensed in your state and if it has a complaint history. Don't forget to find out if the agent is licensed. Ask your agent to check out the insurance too.
2. **Compare, Compare, Compare.** When looking for health insurance, do your homework, get the facts and compare plans. If two plans are similar or identical in benefits but differ a lot in price, it's time to start asking questions. Don't sign on the dotted line.
3. **Be Alert.** Many bogus plans are posting flyers on telephone poles, sending materials across faxes, and advertising on the Internet. If you are looking at enrolling in one of these plans, make sure you ask plenty of questions and get the facts. If it looks too good to be true, it probably is.
4. **Pre-Existing Conditions.** Many insurance companies will not write a policy for a person with a pre-existing condition. If your health plan will and the rate is not substantially higher, start asking questions and researching.
5. **It's All In A Name.** Many bogus plans are using names similar to those of well-known and reputable insurance companies. Check and make sure the plan you think you are enrolling in, is in fact that plan.
6. **No One Is Safe.** Don't think that it can't happen to you--hundreds of thousands of people like you have fallen victim to bogus plans.
7. **Act FAST.** Typically, phony health plans will not pay medical bills or may only pay small ones. If you find that your health insurance is not paying your medical bills in a timely fashion, call your state insurance department and the Department of Labor through its toll-free number at 1-866-444-3272 or at www.askebsa.dol.gov. You need to call FAST and report what is happening to you. Remember, it is better to be safe than sorry.

PREPARED STATEMENT OF HON. JOHN KERRY

Mr. Chairman, thank you for calling this hearing on the important issue of insurance scams and for requesting the GAO study on which it is based. The GAO report is particularly timely as we confront continuing double-digit increases in health insurance premiums, continuing increases in the number of uninsured, and growing concern among those fortunate enough to have insurance that they soon will not be able to afford to maintain it. As we learned during similar periods in the early 1980s and 1990s, these are the times in which health insurance scams flourish. The findings of this report can help us develop policy solutions that will contribute to solving the problem, not exacerbating it.

The GAO report provides essential insights into the very limited effectiveness of current regulatory procedures in deterring scams in the small-group health insurance market and particularly highlights the inadequacy of Department of Labor oversight compared with that of the states. During the period 2000 through 2002, the GAO identified 144 unique unauthorized entities that covered at least 200,000 policyholders and at least \$252 million in unpaid medical claims, only about 21 percent of which had been recovered at the time of the GAO 2003 survey. Every state had at least five such unauthorized entities, although seven states had at least 25 such scams, and Texas topped the list with 31. The report found that 27 percent of these entities characterized themselves as association arrangements and another 8 percent as single-employer ERISA plans. Often these scams chose names similar to well established organizations to enhance their appearance of legitimacy.

Thirty states reported that they issued 108 cease and desist orders that affected 41 of the 144 entities covering 58 percent of the policyholders and nearly half of the claims. The Department of Labor issued temporary restraining orders or injunctions against only 3 entities that combined affected only approximately 13 percent of the policyholders (approximately 25,000) and 15 percent of the claims (approximately \$39 million). In her testimony Assistant Secretary Combs states that finding and shutting down insurance scams is a national enforcement priority and notes that the Employment Benefits Security Administration (EBSA) investigative staff increased 14 percent since President Bush took office. The GAO's finding that during this time the number of new scams identified by DOL and the states almost doubled highlights the inadequacy of DOL capacity to address the problem.

The GAO report also notes how "difficult, time-consuming, and labor-intensive" the DOL process is because of the evidence necessary to document an ERISA violation. At the same time the report describes how quickly the unauthorized entities operate, with the life cycle from initiation to consumer complaints to disappearance of the principals with millions of dollars of premiums often taking less than a year, well ahead of the DOL's enforcement action.

The testimony of Mr. Fred Nepple, representing the National Association of Insurance Commissioners (NAIC), emphasizes that most unauthorized health plans discussed in the GAO report have two factors in common: they claim to offer a plan subject to ERISA, and they, therefore, claim to be exempt from state insurance regulation. The central role that the ERISA exemption from state regulation plays in these insurance scams and the DOL's poor oversight performance are particularly troubling in the context of the Administration's aggressive efforts to create national Association Health Plans (AHPs) under ERISA. AHPs would be under Department of Labor jurisdiction if self-insured or licensed only in a single state if fully insured. They would, therefore, not be subject to the kind of state regulation that the GAO study found was considerably more effective than the oversight provided by the Department of Labor. If DOL is not adequately addressing insurance scams under current ERISA programs, how then could it manage the addition of national AHPs? The opportunity for unscrupulous operators to create new unauthorized entities that could be marketed under the guise of national associations is obvious. Not only will AHPs do little to solve the problem of making affordable high-quality health insurance available to small businesses and their employees desperate to obtain such coverage, they have the potential to greatly exacerbate the problem of insurance scams. Governors, attorneys general, and insurance commissioners, both individually and through their national organizations, have publicly stated their opposition to the Administration's AHP proposal because exempting AHPs from state regulation would be a recipe for disaster.

Instead, creating a single national purchasing pool for small businesses modeled on the Federal Employee Health Benefits Plan could provide the pooled risk, increased purchasing power, experienced administration, and essential consumer protections necessary to give all small businesses real insurance options. The Small Employers Health Benefits Program (SEHBP) Act of 2004 recently introduced by Senators Durbin, Lincoln, and Carper would create such a program. Approaches

such as this one would limit future insurance scams by addressing the underlying conditions that foster them.



Health Policy Institute

Testimony before the

United States Senate
Committee on Finance

On

Health Insurance Challenges: "Buyer Beware."

Mila Kofman, J.D.
Assistant Research Professor
Health Policy Institute, Georgetown University

March 3, 2004

Good morning. My name is Mila Kofman and I am an assistant research professor at the Georgetown University's Health Policy Institute (Institute). Thank you for inviting me to testify on the problem of unauthorized health plans. It is both an honor and a privilege to be here.

As a way of background, researchers at the Institute conduct a range of studies on the uninsured problem. My specific focus is private health insurance, state and federal reforms to improve access to health coverage, and cost of insurance. I have extensively studied the problem of phony insurance and last year published a report studying this cycle of scams, how they work, and what states and the federal government are doing to better protect consumers and help victims. This research was funded by the Commonwealth Fund. I respectfully request that the Issue Brief called "Health Insurance Scams: How Government is Responding and What Further Steps are Necessary" published by the Commonwealth Fund summarizing my findings be entered into the record in addition to my testimony.¹ The detailed report was published by BNA.²

Before joining the faculty at Georgetown University, I was a federal regulator at the U.S. Department of Labor, where I worked on legislation affecting association health plans in addition to regulating such arrangements and implementing federal reforms affecting ERISA health plans. Prior to joining the U.S. Department of Labor, I was Counsel for Health Policy and Regulation at the Institute for Health Policy Solutions, a non-profit, non-partisan firm, assisting small businesses in establishing health insurance purchasing coalitions. My knowledge, therefore, is both practical and academic.

First, I want to thank you for your leadership in investigating the current cycle of health insurance scams. The private market is experiencing a significant problem — criminals defrauding employers and America's workers and their families out of health insurance premiums. Operators of phony health plans target businesses and self-employed people, collect premiums for non-existent health insurance, and leave patients with millions of dollars in unpaid medical bills and without health insurance. For victims, this is worse than being uninsured. When you are uninsured, at least you haven't paid premiums for the privilege of being uninsured. Here, victims are defrauded of thousands of dollars in premiums and then left with huge medical bills.

There has been a long history of scams, with cycles of increased criminal activity. So first, I will give you a historical perspective, which will help explain some of the reasons why we have this problem today. Then I'll discuss how these schemes work focusing on the common elements among the scams I've studied. Then I'll discuss some of the more effective strategies used by states and the federal government in responding to the current wave of scams. In closing I will offer ideas on how to better protect consumers from health insurance scams.

HISTORICAL PERSPECTIVE

This is not the first time that health insurance scams have defrauded American workers and businesses. In fact, this is the third cycle of scams in the last three decades.

First Cycle of Scams: ERISA, 1974 to 1983

The first wave of scams occurred after the Employee Retirement Income Security Act (ERISA), a law federalizing regulation of employee benefits, was enacted in 1974. The influx of scams was an unintended consequence of ERISA.

As you know, ERISA preempts states from regulating ERISA covered employee benefit plans sponsored by private employers. In addition, the original 1974 ERISA statute (pre 1982 amendments) severely restricted state authority to regulate multiple employer arrangements (e.g., a purchasing coalition of employers) that met the requirements to be considered ERISA plans. In reality, however, most multiple employer arrangements were not ERISA plans. But, that didn't stop unscrupulous operators from claiming ERISA preemption when states tried to regulate such arrangements. At the time, the U.S. Department of Labor claimed not to have authority over such arrangements because most were not ERISA plans. Ambiguity about whether states had authority to regulate and limited oversight by the U.S. Department of Labor created opportunities for widespread fraud.

In response, in 1982 (effective 1983) the U.S. Congress amended ERISA to clarify that states could regulate multiple employer arrangements called MEWAs (multiple employer welfare arrangements) even if such arrangements could meet the requirements of an ERISA plan. The clarification removed an ambiguity of which fraudulent operators had taken advantage. This made it possible for states to take more aggressive actions against phony health plans trying to hide behind the ERISA shield.

Second Cycle of Scams: 1988 to 1991

The second wave of scams coincided with double-digit increases in health insurance premiums. In the late 1980s and early 1990s employers faced double-digit premium increases. During the same time period, documented very well by the U.S. General Accounting Office (GAO), MEWA failures, including scams and insolvencies, had increased. During that time MEWAs left thousands of people without health insurance and nearly 400,000 patients with medical bills exceeding \$123 million.³

Through the 1990s as premiums were stable, there were fewer arrangements operating illegally. However, questions about states' authority to regulate MEWAs persisted despite Congressional actions in the early 1980s fixing most of the ERISA problem. Operators of scams continued to use ERISA as a shield, taking advantage of some ambiguities created by the amendment. For example, although Congress clarified that states can regulate MEWAs, collectively bargained union plans are not considered MEWAs and therefore not subject to state oversight. Ambiguity over what is a collectively bargained union plan has resulted in promoters of phony coverage selling these plans through phony unions and holding themselves out as exempt from state oversight as collectively bargained union plans.⁴ In response to this problem, last year, the U.S. Department of Labor issued a regulation to help clarify whether an arrangement is a collectively

bargained union plan exempt from state insurance oversight.⁵ It is too early to tell whether this regulation will prevent promoters of scams from claiming to be a collectively bargained union plan and therefore trying to avoid state oversight.

Third Cycle of Scams: 2000 to unknown

We are in the midst of a third wave of health insurance scams. Since 2000, just four unauthorized entities enrolled over 100,000 people nationwide and left more than \$85 million in unpaid medical claims — which of course the victims are now responsible for paying (See Table 1).

Unlike licensed insurance companies, when an unauthorized arrangement becomes insolvent, there is no safety net like a state guaranty fund to pay claims. So after paying premiums and believing that they have insurance, employers and patients are stuck with medical bills. For some victims this means loss of life's savings and homes, destroyed credit, and in some cases bankruptcy.

The current problem with health insurance scams is national in scope. People in every state, including Alaska and Hawaii, have been defrauded. In Florida health insurance scams have left nearly 30,000 people without health insurance and unpaid medical bills. A regulator from Oklahoma reported that in 2002 she had 60 open investigations — more than she's ever had in her 20 some years with the insurance department (see Table 2 for a summary of state activities between 2000-2002). Louisiana established an emergency team to find and shut down scams. Other insurance departments shifted staff to investigate and shut down scams.

The recent wave of health insurance scams, consistent with history, can be attributed to greater demand for affordable health insurance in the face of double-digit increases in premiums. Employers and individuals who are desperate to find affordable coverage are at risk of being conned by scams.

HOW SCAMS WORK

Research Methodology

This research, funded by the Commonwealth Fund, on the magnitude of this current scam problem also looked at state and federal strategies that seem to be working in combating this problem.

I interviewed state insurance commissioners, insurance regulators, civil and criminal investigators, and legal counsel from eight states (Arkansas, California, Colorado, Florida, Indiana, Louisiana, Texas, and Wisconsin). At the federal level I interviewed U.S. Department of Labor regulators and investigators from the Employee Benefits Security Administration and the Inspector General's Office. I also interviewed attorneys at the U.S. Department of Justice, current and former FBI agents with experience in insurance fraud, a litigator from a state Attorney General's office who litigated MEWA cases in the early 1990s, a local prosecutor specializing in insurance litigation, court appointed receivers and their attorneys for the two

largest entities closed by the states and federal government, a forensic accountant, insurance agents solicited to sell unauthorized coverage, and a professional association for agents.

Façade of Legitimacy

Promoters of phony health insurance utilize strategies that make the health plan appear legitimate. Their plan documents and marketing materials resemble materials from licensed insurance companies. Promoters contract with existing provider networks and issue medical cards using the name of the provider network.⁶

To promote the façade of legitimacy, they use licensed agents to market their phony products. Operators recruit agents by paying high commissions. One arrangement paid its agent consultants \$50 per month for single enrollees and \$100 per month for each enrolled family.

To grow rapidly, they sell to existing legitimate trade and professional associations. They also set up their own phony associations. Employers Mutual LLC, a nationwide unauthorized entity that collected \$15 million in premiums and left people with over \$27 million in unpaid medical bills, sold coverage to the National Writers Union, a professional association for journalists. Promoters also sold coverage through sixteen associations they established, collecting membership fees in addition to premiums from people who joined.⁷ Operators of American Benefit Plans, another unlicensed entity, sold their health plan through at least seven existing associations and four associations they created — National Association for Working Americans, National Association of Working Americans, the United Employee Voluntary Employee Beneficiary Association, and the United Employee Voluntary Employee Beneficiary Association (emphasis added).⁸ They enrolled over 32,000 people in forty-eight states.

Unauthorized arrangements use familiar names of existing companies. For example, the name Employers Mutual LLC resembles Employers Mutual Casualty Company, a licensed insurance company in business for nearly a century. An unauthorized arrangement (shut down by Florida's regulators) called Vanguard Asset Group resembles Vanguard Group, a well-recognized investment management company with more than \$550 billion in assets.⁹ The use of names resembling existing companies misleads agents and leads consumers to believe that they are purchasing coverage from a well-known company.

Once operating, unauthorized plans pay small claims and delay paying large ones. This ensures that consumers continue paying premiums. Monthly premiums from existing and new enrollees coupled with not paying claims may mean millions of dollars every month in profit for operators of unauthorized health plans. In law enforcement circles, these schemes are called “cash cows.”

Low Prices and Comprehensive Benefits

Illegal arrangements sell comprehensive coverage to small businesses, self-employed people, and professional and trade associations — those that otherwise might not be able to afford it or those looking for alternatives to their existing coverage due to double-digit premium increases. Operators set prices below market rates and enroll people without medical underwriting (regardless of their medical history). For example, according to a federal judge, Employers Mutual LLC set rates by “averaging sample rates posted on the internet and then reducing them to enable Employers Mutual [LLC] to compete with other providers.”¹⁰ That arrangement

charged a 50 year-old woman, for example, a monthly premium of \$285 compared to \$425 for comparable benefits from a licensed insurance company. Consumers are taken in by what they perceive as a good deal and pay premiums unaware that coverage is offered by unauthorized plans, that the company may be insolvent or potentially fraudulent.

ERISA Shield

Operators of health insurance scams claim their products are cheaper because they are not regulated by states and that they are regulated by the federal government under ERISA. Some create complex legal documents that, at least on paper, raise questions about their legal status.

Although Congress clarified ERISA twenty years ago, some ambiguities remain and operators of phony health plans continue to use ERISA preemption as a shield to avoid state enforcement actions, challenging state authority by removing cases to federal court. In the case of American Benefit Plans, although the Texas Insurance Department had a letter from the U.S. Department of Labor stating that the arrangement was subject to state regulation, one of its promoters removed the state case to a federal court. This is a tactic used by operators to delay final court action, which gives operators of phony health plans an opportunity to spend or hide assets (e.g., in offshore accounts).

Experienced Operators

The financial rewards of operating phony health plans are so great, even civil actions pose little deterrent effect. Once a promoter of an unauthorized arrangement figures out how to establish and operate it, being caught does not deter establishing new ones. For example, in 2000, Dwayne Samuels “pleaded guilty to healthcare fraud in connection with the embezzlement of some \$8 million” through a phony union plan and a phony employer association.¹¹ He “was barred for life by the U.S. Department of Labor from having any dealings with or receiving compensation from employer benefit plans.”¹² He ignored his plea agreement and operated another illegal arrangement shut down by Florida’s insurance regulators in 2002.

In the case of Employers Mutual LLC, its vice president James Graf also operated Prime Care Health Networks, Inc., which was shut down by California’s Insurance Department in 1998. He was also affiliated with the National Consumers Benefits Association, shut down by California’s Insurance Department in 2000.¹³ Around the same time, Graf became vice president of Employers Mutual LLC.¹⁴

Impact on Consumers

Many consumers who fall into this trap are often victimized more than once. Some agents involved with unlicensed plans repeatedly enroll their customers in unauthorized entities. For example, a licensed agent in Hawaii with a high volume of enrollees in the Hawaii HealthCare Alliance (HHA) — an unauthorized arrangement that left hundreds of thousands of dollars in unpaid medical bills and was shut down by the insurance department — enrolled HHA consumers into the TRG plan, another unauthorized arrangement, whose operators have been indicted on criminal charges in Florida and if convicted, could face up to 60 years in prison.¹⁵

Once consumers learn that their insurance is a scam, unfortunately in many states there are no options in the regulated market. Many people are shut out of the private market due to existing medical conditions. Victims, with medical conditions, lucky enough to find private insurance face preexisting conditions exclusion or are surcharged.

One state insurance regulator summarizes what happens when an unauthorized health plan falls apart:

[It leaves] behind thousands of uninsurable victims with millions of dollars in unpaid claims. Everyday, good, honest people — facing personal illnesses or the pain and suffering of a loved one while trying to avoid creditors and collection agencies hounding them for payment, medical providers refusing treatment, and wondering if they are going to lose everything they have worked for all their life. These people call me everyday — they rant and they rave and sometimes they weep.¹⁶

GOVERNMENT RESPONSE

Both states and the federal government share oversight responsibility. As I mentioned earlier, unlike with single employer plans covered by ERISA, any arrangement covering employees of two or more employers or self-employed people is subject to both federal and state jurisdiction. Under ERISA such arrangements are called MEWAs. State and federal authority and tools vary and are complementary.

Complementary Federal and State Authority

The laws and legal tools available to states and the federal government are complementary. Accordingly, some of the most successful actions have resulted from coordinated investigations by states and the federal government.

State regulators have administrative authority such as cease and desist orders (C & D Orders) enabling states to quickly close an unauthorized entity without going to court. C & D Orders help stop the spread of an illegal plan within the state and in some cases can result in regulators' seizing assets. States also have receivership authority, which is often the only way to find assets to pay claims of victims. In one of the most successful receiverships — American Benefits Plans, which is an on-going state receivership — the receiver has been able to identify and seize \$8 million in assets. To put this in context, during the last cycle of scams between 1988 and 1991, victims were left with over \$123 million in unpaid medical bills. Less than \$9.6 million in assets was recovered.¹⁷

By contrast, federal regulators must ask a federal court to close an unauthorized plan and to establish a receivership. Federal actions are much slower than state actions in this area. The U.S. Department of Labor must go to federal court and overcome a high evidentiary burden. It may take several years, in fact, to have enough evidence to prove a case in court. For example, in the case of TRG, Hawaii and Kentucky's insurance departments issued orders to shut down TRG in November 2001 (with at least 8 other states following). One state (Florida) had enough evidence for a grand jury to indict operators of TRG last year. Two years after the first state actions, the U.S. Department of Labor filed its civil complaint in federal court. Time is critical

in health insurance scam cases. The more time these operators have, the more opportunity there is to hide or spend assets – funds that otherwise could and should be seized and used to pay claims. Filing a civil case 2 years after a state takes action may mean that all assets will disappear. This means that employers and people covered by TRG will be paying their own medical bills – bills that should have been paid by TRG.

Although federal actions are slow, their effect is nationwide compared to state actions being limited within a state's borders.

Prevention and Early Detection

Prevention is the only way to protect the public against health insurance scams because once operating, it's certain that victims will be stuck with medical bills. Unfortunately, few of those most at risk – small business owners and self-employed people – know about phony health plans. A study by Nevada's Insurance Commissioner found that only 3% of small businesses in the state were aware of the existence of unauthorized insurance.¹⁸ In response, Nevada's Insurance Commissioner launched a consumer education campaign that includes TV, radio, and print media. Through an arrangement with the Nevada's Broadcaster's Association, the Insurance Division is getting \$400,000 worth of air time for \$108,000 (includes all expenses and television and radio production; the combined spots will air approximately 1,000 times per month throughout Nevada.).¹⁹

Even broad and well-financed educational efforts, however, fail to completely prevent consumers from becoming victims. Thus, prevention must be coupled with aggressive oversight and early detection of problems. Early detection means using licensed insurance agents as the "eyes and ears" of the insurance department to identify unlicensed arrangements before they proliferate. Licensed agents are in the field and often are the first to see a potential problem when they are solicited to sell illegal coverage. Agents also lose business to illegal companies offering cheaper coverage and so have an incentive to alert regulators to problems. In a recent case in Louisiana, as a result of a tip from an agent, insurance department staff attended a marketing meeting for an unauthorized health plan. Evidence from this meeting enabled the Department to close the plan within eighteen days of the marketing meeting.

By contrast, the U.S. Department of Labor does not have this early detection tool. Reporting "unlicensed" arrangements is not necessary because ERISA plans are not licensed by the Department. Additionally, the federal government does not regulate agents and thus could not encourage nor compel agents to report suspicious activity. Not having agents to function as regulators' "eyes and ears," makes it almost impossible for federal regulators to detect problems early.

Other strategies include identifying suspicious behavior through consumer complaints. However, when consumers call, there is already a problem with unpaid bills. Nonetheless, a quick response can prevent the illegal arrangement from growing. States have developed effective strategies to utilize information from consumers. Techniques such as sharing with customer service staff names of identified arrangements and operators known to be operating in other states, special workshops for customer service staff, or automatic referrals for investigation are just some of the many techniques that states use to effectively utilize information from consumers in order to identify problems early.

Federal regulators also recognize the value in receiving information from consumers. Although the U.S. Department of Labor typically initiates investigations when there is a pattern of complaints, some of its field offices have initiated investigations when one consumer calls with a large claim not being paid. Given the long history of fraud related to MEWAs, the Department of Labor should not rely on patterns before fully investigating complaints. Instead such investigations should be automatic after receiving information from a single consumer calling with the problem of unpaid medical claims by a MEWA.

Criminal Actions

Both state insurance departments (either directly or by working with other state law enforcement agencies) and the U.S. Department of Labor investigate criminal cases. The states and the federal government have a variety of tools to hold perpetrators of health insurance scams accountable criminally. Criminal statutes for white-collar crimes, such as fraud, however, require extensive evidence, which may not always be available due to the nature of the crime. According to state and federal investigators, including ex-FBI agents who conducted undercover operations examining unauthorized arrangements, criminal cases require extensive resources.

Even aggressive civil actions against operators of phony plans, however, are not enough to stop repeat offenders. Civil actions are merely a cost of doing business to these operators. More criminal prosecutions are necessary especially at the federal level because in most cases, unauthorized plans operate nationally. For example, it could be difficult to get a Texas jury to convict someone responsible for harming a consumer in California. Similar to other white-collar crimes, unfortunately, the criminal justice system has often failed to punish perpetrators of health insurance scams with jail time.

At the federal level, it is the responsibility of the Justice Department through their Assistant U.S. Attorneys to prosecute these cases (see Table 3 for examples of federal criminal charges available). A number of factors contribute to the problem of why the Justice Department has not indicted criminally promoters of phony health plans that have been shut down in the last 3 years. One reason is jury convictions for insurance fraud can be difficult to obtain. Such trials can involve complex financial transactions and difficult insurance issues, and are often document intensive and complicated. Due to resource issues, complexity of white-collar crimes, and priorities, it may be a challenge to find a prosecutor in every U.S. Attorneys office interested in taking such a case.

RECOMMENDATIONS

Congress can and should take immediate, specific actions to slow the spread of health insurance scams and to help the victims of these scams. Perpetrators must be held accountable for their actions.

First, public awareness can help prevent the spread of health insurance scams. To that end, Congress can allocate resources and require the U.S. Department of Labor to undertake a nationwide consumer education campaign, perhaps similar to Nevada's campaign I discussed earlier. Any education campaign must tell consumers that they should check with their state

insurance department to ensure that the company they are buying insurance from is authorized in their state.

Second, Congress can clarify ERISA to prevent it from being used as a shield against state oversight. Amending ERISA to prohibit removal from state to federal court cases involving MEWAs will greatly help reduce delay tactics used by operators of phony plans and will help minimize using ERISA as a shield.

Third, Congress can require the U.S. Department of Labor to issue timely advisory opinions when a state needs help to avoid ERISA challenges to state authority by promoters of scams. It is expensive for states to litigate these issues in federal court. One state spent half a million dollars litigating an ERISA preemption issue. Often, only states investigate unauthorized plans and only states can close an entity quickly through an administrative action (without going to court). Advisory letters would also greatly benefit affected consumers by allowing states to take quick action without being forced to defend their jurisdiction when challenged on ERISA preemption grounds.

Fourth, Congress can amend ERISA to give the U.S. Department of Labor new enforcement tools such as cease and desist authority. Within constitutional parameters the Department should be given authority to seize assets without obtaining a court order first. This will help augment current state authority and empower federal regulators to be more effective. Both would help the Department to close an insolvent arrangement quickly and prevent assets from disappearing by avoiding lengthy actions in federal court. Absent such changes in federal law, only states can quickly close a phony health plan. Quick action is critical to protect victims by preventing assets from disappearing and stopping the phony plan from proliferating.

Fifth, Congress should require the Justice Department to more aggressively pursue cases against promoters of phony health insurance. Civil actions do not stop those who engage in criminal conduct. They change their name, move to another state, and repeat the scam. What is necessary are criminal actions that result in a jail sentence. To that end, the federal government should be more aggressive with criminal prosecutions.

Finally, a clear solution is to strengthen existing safety-net programs and to enact laws that will enable people and businesses to find affordable health insurance. Take away the demand, and there will be a drop in supply of illegal health plans. Absent comprehensive reforms, Congress could and should enact new laws to help victims of phony health plans who are stuck with thousands of dollars in unpaid medical bills.

Thank you for your consideration of this important issue and I look forward to assisting you as you look for ways to better protect America's workers, their families, and businesses.

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Table 1. Examples of Unauthorized Health Plans, 2001-2002

Health Plan	Victims	Outstanding Medical Claims	Premiums Collected	Assets	States Involved
American Benefit Plans	40,000	\$43.3 million*	unknown	\$5.3 million**	Nationwide
Employers Mutual, LLC	30,000	\$27 million***	\$15 million	\$650,000	Nationwide
Local 125	2,725	\$13.3 million	unknown	\$627,000	41
TRG****	12,288	unknown	\$17 million	unknown	44
Vanguard Asset Group	160	\$1.2 million	unknown	unknown	Florida

* Total claims filed with the Receiver by 13,229 employers, patients, and providers. Some may be duplicate claims.

** Total of \$8 million was found and collected successfully by the receiver, appointed by the insurance department, at a cost of \$2.7 million in litigation fees, expert consultants, and staff resources. An additional \$2 million to \$3 million has been found but not yet recovered.

*** An estimated \$54 million in claims have been filed. However, some of these claims may be duplicated—filed by providers in addition to the filing by the patient. Also, some claims may have been filed for individuals not eligible for coverage.

**** According to one news account, TRG covered between 20,000 and 40,000 people. According to Florida's Insurance Department, based on only 400 complaints (one consumer may have filed several complaints), there are over \$2.6 million in unpaid medical bills.

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Table 2. State Actions, 2000-2002

State	Date	Total # of Entities/ Individuals Affected by Order	# Entities	# Individuals
Arkansas	2002	20	13	7
California	2002	12	10	2
Colorado	2002	43	25	18
	2001	30	20	10
Florida	2002	52	35	17
	2001	31	29	2
Louisiana	2002	26	15	11
Nevada	2002	23	12	11

	2001	45	18	27
Texas	2002	104	65	39
	2001	25	21	4
Wisconsin	2000	6	5	1

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Table 3. Federal Criminal Statutes Applicable to Health Care Related Crimes*

TYPE	CITATION	DESCRIPTION
ERISA	Section 411 (29 U.S.C. 1111)	Prohibition Against Certain Persons Holding Certain Positions
	Section 501 (29 U.S.C. 1131)	Criminal Penalties
	Section 511 (29 U.S.C. 1141)	Coercive Interference
18 U.S.C.	Section 2	Principals
	Section 371	Conspiracy
	Section 664	Theft or Embezzlement from Employee Benefit Plans
	Section 669	Theft or Embezzlement in Connection with Health Care
	Section 981	Civil Forfeiture
	Section 982	Criminal Forfeiture
	Section 1027	False Statement and Concealment of Facts in Relation to Documents Required by the Employee Retirement Income Security Act
	Section 1033	Crimes By or Affecting Persons Engaged in the Business of Insurance Whose Activities Affect Interstate Commerce
	Section 1035	False Statements Relating to Health Care Matters
	Section 1341	Mail Fraud
	Section 1343	Wire Fraud
	Section 1345	Injunctions Against Fraud
	Section 1347	Health Care Fraud
	Section 1349	Attempt and Conspiracy (applicable to fraud charges)
	Section 1954	Offer, Acceptance or Solicitation to Influence Operations of Employee Benefit Plans
	Section 1956	Laundering of Monetary Instruments
	Section 1957	Engaging in Monetary Transactions in Property Derived from Specified Unlawful Activity

*Not a complete listing of available charges.

¹ Mila Kofman, Kevin Lucia, and Eliza Bangit, *Health Insurance Scams: How Government is Responding and What Further Steps are Needed*, The Commonwealth Fund (August 2003) available at www.cmf.org.

² Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond*, BNA Plus (2003).

³ U.S. GENERAL ACCOUNTING OFFICE, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40, at 2-3 (Mar. 10, 1992) (hereinafter 1992 GAO Report).

⁴ In 1991, the GAO told Congress that the U.S. Department of Labor needs to issue regulations clarifying union status. 1992 GAO Report at 9.

⁵ Procedures for Administrative Hearings Regarding Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA, 68 Fed. Reg. 17472 (Apr. 9, 2003) (to be codified at 29 C.F.R. part 2510 and 2570).

⁶ Agents and consumers recognize well-known provider networks and don't become suspicious until it is too late.

⁷ *Chao v. Graf*, et al, CV-N-01-0698-DWH-RAM, at 2-3 (D. Nev. Feb. 1, 2002) (court issued a preliminary injunction) (hereinafter Federal Court Order Employers Mutual).

⁸ Texas Petition for Temporary Restraining Order at 5, *Texas v. American Benefit Plans et al.*, Cause No. GV200903 (Tx. D. Travis County Mar. 6, 2002) (hereinafter ABP Petition). ABP also allegedly sold coverage through the American Association of Agriculture, Forestry, and Fishing Workers; the American Association of Transportation, Communication, Electrical, Gas, and Sanitary Workers; the American Association of Wholesale Trade Workers; the American Association of Manufacturer Workers; the American Association of Service Workers; the American Association of Construction Workers; and American Association of Professional Workers. *Id.* at 6-7.

⁹ Information about Vanguard Group is available at <http://flagship.vanguard.com>.

¹⁰ Federal Court Order Employers Mutual at 4.

¹¹ Department of Insurance (Florida): Immediate Final Order, *Vanguard Asset Group et al*, Case No. 43162-02 CO, at 11 (May 10, 2002) (hereinafter Vanguard C & D Order).

¹² Vanguard C & D Order at 10.

¹³ See *In the Matter of National Consumers Benefits Association et al*, File No. OC 110-AP at 17, Hearing Before the Insurance Commissioner of the State of California (Oct. 5th, 2000).

¹⁴ Federal Court Order Employers Mutual at 2-3.

¹⁵ *Commissioner Warns Against New Unauthorized Health Insurance Plan*, State of Hawaii Insurance Division, Press Release, Dec. 26, 2001. See *Gallagher, Posey Announce Felony Charges Against Operators of Unlicensed Insurance Entity*, Florida Department of Financial Services, Press Release, Apr. 14, 2003.

¹⁶ Pamela Williams, Assistant Commissioner, Office of Health Insurance, Louisiana Department of Insurance, *Multiple Employment Welfare Arrangements* (2003) (unpublished presentation material) (on file with author).

¹⁷ 1992 GAO Report at 22.

¹⁸ InfoSearch International, *Unauthorized Insurance Awareness Study*, at 4 (Feb. 2003) (Report for the Nevada Department of Insurance).

¹⁹ These ads will not be typical public service announcements seen in the middle of the night.



TASK FORCE ON THE FUTURE OF HEALTH INSURANCE

Issue Brief

AUGUST 2003

Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed

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The Commonwealth Fund is a private foundation supporting independent research on health and social issues. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff, or to members of the Task Force on the Future of Health Insurance.

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The United States is experiencing an unprecedented influx of unauthorized insurers selling phony health insurance. The last time this occurred, more than a decade ago, nearly 400,000 people were left with \$123 million in unpaid medical bills. Unauthorized health insurance companies intentionally fail to comply with state and federal law regarding insurance regulation; they collect premiums for nonexistent health insurance; they do not pay claims, and, ultimately, they leave patients with millions of dollars in medical bills. Since 2001, four of some of the largest unauthorized plans have left nearly 100,000 people with approximately \$85 million in unpaid medical bills and without health coverage. Most victims have been small businesses and self-employed people. Regulators believe this problem will only grow as premiums continue to increase at double-digit rates and people continue to look for affordable alternatives.

It is illegal in every state to operate an insurance company without a license. By not obtaining a license, unauthorized insurers are able to avoid compliance with important consumer protections, including solvency standards that ensure a company will be able to pay claims of enrolled individuals, safeguards for vulnerable populations (e.g., children with disabilities), states' health coverage continuation and conversion laws, and other consumer protections. When an unauthorized company becomes insolvent, there is no safety net, such as a state guaranty fund, to pay medical claims. Having paid insurance premiums in the belief that their medical care would be covered, victims are left to deal with often huge medical bills. Some lose their homes and life's savings. With collection agencies aggressively pursuing victims to pay outstanding medical bills, a number of patients are saddled with bad credit or forced into bankruptcy.¹

This issue brief highlights state and federal strategies that have been successful at identifying and closing unauthorized health plans, as well as methods of preventing their proliferation. It also makes recommendations to strengthen the roles of state and federal regulators and insurance agents as watchdogs against phony insurance.

BACKGROUND

Health insurance scams exist because there is an unmet need for affordable coverage. Those that operate phony health plans market a low-priced, comprehensive coverage option. Historically, scams have proliferated when insurance premiums increase substantially. State and federal regulators believe that the United States is currently at the beginning of the newest cycle of scams; as premiums continue their double-digit growth, many believe that there will be more victims.

Unauthorized health plans attract business by undercutting competition with low prices and accepting enrollees without medical underwriting, regardless of their past or present medical conditions. One unauthorized plan, for example, charged a 50-year-old woman a monthly premium of \$285—an unusually low rate for comprehensive coverage offered in a state that allows rates to be based on one's age and health status. A licensed insurance company charged her \$425 for similar benefits, which is more reflective of the rate typically charged for a 50-year-old in relatively good health.²

When questioned by consumers and agents, promoters of unauthorized insurance claim that premiums are low because, as group purchasing arrangements, they are able to use their collective purchasing power to negotiate lower prices from insurance companies. Additionally, they may claim that the type of plans they offer are exempt from state insurance laws—for example, union plans—and that their low premiums result from this exemption. In reality, these claims are false.

Phony plans spread because they have a facade of legitimacy. They may contract with well-recognized national provider networks, name

themselves after existing companies, use marketing material that appears legitimate, or recruit licensed agents to sell their coverage. They proliferate rapidly by selling coverage through bona fide as well as phony professional and trade associations.

Once in operation, most unauthorized plans pay small claims but delay paying the large ones. This tactic deflects suspicion and gains the confidence of both consumers and insurance agents, thus ensuring continued participation and payment of premiums. The suspicions of health care providers and patients may not be aroused immediately, however, because both have grown accustomed to delays in claims payment. Not paying claims, coupled with a monthly flow of premium payments from existing and new, unsuspecting insurance consumers that sometimes can reach millions of dollars per month, can mean huge profits for promoters of phony coverage. One plan collected \$1.6 million in premiums and paid only \$360,000 in claims; its operator diverted more than \$900,000 for personal use.³ Another company collected \$15 million in premiums while paying only \$3 million in claims.⁴

Operators of unauthorized health plans are often repeat offenders. Once promoters of an unauthorized plan figure out how to operate it, they can easily establish new ones, even after being caught. Moreover, consumers who fall into this trap are often victimized more than once.

Once consumers have medical conditions, or merely medical claims, their opportunities to purchase health insurance may be impaired. In most states, self-employed individuals and others seeking to purchase individual policies must pass medical underwriting, which means they can be denied coverage because of their existing or past medical conditions. Small businesses may also have difficulty buying new coverage. Even though there are insurers in each state that offer coverage to small businesses, the premiums can be high, especially when people covered by these policies have medical conditions. In many states, once consumers get sick, they have few or no options in the regulated

market, and a number of these individuals end up buying coverage from unauthorized companies.

The First Wave: Enactment of ERISA, 1974–83

The first wave of scams followed the 1974 enactment of the Employee Retirement Income Security Act (ERISA), which federalized the regulation of employee benefits. ERISA severely restricted state authority to regulate group purchasing arrangements—a policy that led to unintended consequences. Operators of unauthorized health plans began to sell coverage through group purchasing arrangements called multiple employer trusts (METs) (Table 1). When states tried to regulate arrangements that were not subject to ERISA, including most METs, their operators successfully claimed ERISA exemption from state law.⁵ However, the U.S. Department of Labor claimed not to have authority over such arrangements because most were not ERISA plans.⁶ Ambiguity about whether states had authority to regulate group purchasing arrangements, as well as limited oversight by the U.S. Department of Labor, created opportunities for widespread fraud.

Congress responded in 1982 when it amended ERISA to clarify that states could in fact regulate multiple employer welfare arrangements (MEWAs) (health plans for employees of two or more employers or self-employed people). At the time, regulators believed that the ERISA amendments had had their desired effect. Although some

health insurance scams surfaced, there were fewer unauthorized arrangements.

The Second Wave: Double-Digit Premium Increases and ERISA Ambiguities, 1988–92

The second wave of scams coincided with double-digit increases in health insurance premiums beginning in 1988, a year when employers faced average premium increases of 12 percent.⁷ According to the General Accounting Office, increasing problems with unauthorized MEWAs from 1988 to 1991 left thousands of people without health insurance and nearly 400,000 patients with medical bills exceeding \$123 million.⁸

Continued ambiguity over states' authority to regulate MEWAs was also to blame. ERISA exempts collectively bargained union plans from its definition of a MEWA, meaning that states do not regulate such plans. But uncertainty concerning what constitutes a collectively bargained union plan led to health insurance scams promoted through phony unions.⁹ According to the U.S. Department of Labor, one MEWA purporting to be a union plan left 3,600 people in 32 states with some \$25 million in unpaid claims.¹⁰

While the U.S. Congress has not clarified ERISA since 1982, the U.S. Department of Labor did issue a final regulation in April 2003 to help identify collectively bargained union plans.¹¹ The regulation allows for an administrative hearing to determine whether an arrangement is a collectively

Table 1. How Unauthorized Health Insurance Is Sold, 1974 to Present

Cycle of Fraud	Unauthorized Arrangements
1970s	• Multiple Employer Trusts (METs)
1988–92	• Multiple Employer Welfare Arrangements (MEWAs) • Phony unions • Employee Leasing Firms/Professional Employee Organizations (PEOs) • Association Health Plans (AHPs)
2001—	• Phony unions • Employee Leasing Firms/Professional Employee Organizations (PEOs) • Association Health Plans (AHPs) • Discount health plans

bargained plan exempt from state law. To avoid such proceedings from being used as a ploy to evade state actions, the regulation specifies that they may not be used as “the basis for a stay or delay of a state administrative or court proceeding or enforcement of a subpoena.”¹² How effective this will be remains to be seen.

Third Wave of Scams: Current Crisis, 2001 to Present

Since 2001, insurance scams have been proliferating once again. State and federal regulators believe that the number and magnitude of unauthorized plans are rapidly growing and spreading around the country. Recently, two nationwide scams left 70,000 people with an estimated \$70 million in unpaid medical bills and without health insurance. In the last two years, the Texas Insurance Department shut down 129 unauthorized insurance companies, affiliates, operators, and their agents whose illegal actions affected more than 20,000 Texans.¹³ Florida has likewise seen a tremendous increase in the proliferation of such plans, with nearly 30,000 residents left without coverage and burdened with unpaid medical bills.¹⁴ In December 2002, the U.S. Department of Labor reported it had 107 civil and 19 criminal investigations open nationwide.¹⁵

The recent influx of unauthorized plan operators can be attributed to greater demand for affordable health insurance as a result of double-digit premium increases, as well as ambiguity in federal law. In 2001, businesses with three to nine workers paid an average of 16.5 percent more for health insurance than in 2000.¹⁶ In 2002, premiums increased by an estimated 15.4 percent.¹⁷ Some analysts predict an additional 20 percent increase in 2003.¹⁸ As employers face such increases, they will continue to seek alternatives to traditional health coverage. Determined to keep their insurance costs down, a number of these firms inevitably will be taken in by offers of low-priced premiums that are, literally, too good to be true.

Operators of unauthorized plans continue to

use ERISA preemption as a shield to avoid state enforcement actions, selling coverage through professional and trade associations, phony unions, and professional employee organizations (PEOs). Arguably, all of these arrangements raise questions about state jurisdiction, as when phony unions sell unauthorized insurance and then claim ERISA preemption when discovered by state regulators. Selling through PEOs raises additional questions. ERISA permits only the federal government to regulate single employer health plans; both the federal government and states, however, can regulate multiple employer welfare arrangements. When asserting jurisdiction over PEOs, state regulators are forced to answer a factual question of whether a PEO is a single or multiple employer plan—a difficult challenge without a bright-line rule to guide them.

State regulators also note an increase in unauthorized insurers disguising themselves as discount health plans. While not claiming ERISA exemption, these operators claim exemption from state law because, by definition, state insurance laws apply only to insurance. In some respects, a legitimate discount plan can operate in most states free of either federal or state oversight by negotiating discounts with provider networks.

Unlike health insurance, discount plans do not pay claims. Instead, they charge consumers a monthly fee in exchange for discounts they negotiate with providers. According to state regulators, promoters of unauthorized coverage can use discount plans as a subterfuge in one of two ways: by establishing a discount plan that pays claims and therefore should be subject to state insurance law, but in fact operates without a license; or by collecting monthly fees without actually negotiating discounts with providers. In both cases, consumers are the victims.

STATE AND FEDERAL RESPONSES

The states and the federal government are trying to respond to the surge in health insurance scams through prevention, early identification, and expe-

dited action (Table 2). Successful strategies are driven by good laws and by the creativity and commitment of state and federal regulators, investigators, and prosecutors.

Prevention

Consumer Education

A study by Nevada's insurance commissioner found that only 3 percent of small businesses in the state knew that unauthorized health insurance plans exist.¹⁹ State and federal regulators have developed education campaigns to warn small businesses and self-employed people about unauthorized plans. In addition to being a good preventive measure, regulators consider such investment cost-effective compared with the cost of identifying and closing down an active health insurance scam—one state spent more than \$500,000 closing just one entity.²⁰ Earlier this year, the National Association of Insurance Commissioners (NAIC) began looking at ways to develop a national consumer education campaign.

Agent Education

Promoters of unauthorized health plans rely on licensed agents to sell their coverage. To prevent these plans from doing this, some state regulators require that agents receive training about unauthorized insurers before receiving their license or on an annual basis. In addition to required course-

work, state regulators disseminate information through agent associations, meetings, publications, and insurance department bulletins.

Regulators believe that education about unauthorized plans must be coupled with information about penalties and agent liability.²¹ Colorado's Insurance Department disseminates summaries of actions against agents who have sold unauthorized coverage to discourage agents from doing so. Agents can be personally liable for unpaid medical bills when they sell such coverage. Even experienced agents can be trapped into selling unauthorized plans.

The NAIC has developed and issued a model alert for agents, including information about their reporting responsibility and tips on how to identify phony arrangements. The alert was disseminated by many insurance departments and by the National Association of Health Underwriters, a professional association for agents and brokers.

Verification Tools

State regulators say that public education initiatives are effective only if they are supplemented with tools that give consumers and agents access to information on the legal status of an insurance company. All states examined for this study use their customer service staff to help consumers and agents verify whether a company is authorized to

Table 2. Government Responses to Health Insurance Scams

Government Response	Strategies
Prevention	• Consumer and agent education • Couple education with tools to verify whether a health plan is licensed and authorized to sell coverage in the state
Early Identification	• Use agents to identify unauthorized arrangements • Identify suspicious behavior through consumer complaints • Coordination within and among government agencies • Warn the public about arrangements operating without a license
Expedited Action	• Share evidence and perform joint investigations to close an unauthorized plan • Coordinate information and investigations between state insurance departments and the U.S. Department of Labor

sell health insurance. Moreover, insurance departments in California, Florida, and Texas use their websites to allow consumers and agents to research insurance plans. Several states use the insurance department's agent licensing divisions to respond to agent inquiries about companies.

Early Identification

Using Agents as Eyes and Ears

Insurance agents can act as informants for their state insurance department and assist in early detection of unauthorized health plans. Agents often report suspicious activity and sometimes even collect information for the insurance department. In those states that have adopted regulations based on the NAIC's model reporting requirements, agents must report unauthorized entities or face legal and financial consequences, including liability for unpaid medical bills if the entity fails to pay. So far, 17 states have adopted such regulations.²²

Consumer Complaints

State regulators recognize that consumers can be a source of valuable information about unauthorized plans. In most cases where consumers contact the insurance department, however, they are doing so because of unpaid medical bills—indicating that a problem already exists. Some states provide special training for staff who handle consumer complaints related to unauthorized insurers. Others have special procedures for handling complaints: in Wisconsin and Arkansas, for example, inquiries about MEWAs are directed automatically to the General Counsel's office for investigation.

Federal regulators also recognize the value of consumer information. The Employee Benefits Security Administration (EBSA) trains its customer service staff to deal with health coverage scams. Although most federal investigations are not initiated until there is a discernable pattern (e.g., more than one consumer with unpaid claims), some field offices have initiated investigations when a consumer reports a large, unpaid claim—often a clear signal that a serious problem exists.

Coordination

To prevent widespread fraud, some state regulators coordinate with multiple agencies within their state as well as with other states and the federal government. Some insurance departments have formed an internal task force to watch for suspicious behavior. Colorado's insurance commissioner, for example, established a working group of division directors from consumer services, agent licensing, financial, enforcement, and forms and rate filings divisions.

Each state insurance department studied appoints a person responsible for working with other states. The NAIC has taken a leadership role in encouraging coordination among states by developing a watch list that includes information about unauthorized arrangements, their management, and where they are selling. While state officials consider these exchanges valuable, they recognize that not all states provide the NAIC with the necessary information to ensure that the list is comprehensive.

State and federal regulators also coordinate their efforts to pursue and prosecute unauthorized insurers. NAIC and EBSA, for example, exchange information about open investigations. Both state and federal officials report that such exchanges help to expedite action.

Warning the Public

Regulators believe that news releases are an effective way to notify the public that the insurance department or federal government has closed down an unauthorized insurance plan. Many regulators cultivate relationships with the media to help disseminate news.

In many cases, unauthorized plans have already enrolled a significant number of people by the time they come to the attention of regulators. To mitigate the effects of one unauthorized plan, Nevada's insurance commissioner alerted enrolled employers before taking final administrative action. Regulators made telephone calls and sent letters to enrollees indicating that their coverage had been

purchased from an unauthorized company and that, if the plan became insolvent, medical claims may not be paid. According to the insurance department, many enrollees stopped paying premiums and found new coverage.

Expedited Action

Share Evidence and Perform Joint Investigations

States have initiated joint investigations into unauthorized plans that operate in more than one state. The NAIC facilitates coordination among various state investigations by creating teams and identifying leaders. Regulators believe this is an effective way to expedite investigations and use resources efficiently.

Coordinate Between State Insurance Departments and U.S. Department of Labor

The laws and legal tools available to states and to the federal government are complementary. State regulators have administrative authority, such as cease-and-desist orders, enabling them to close an unauthorized entity without going to court. States also have receivership authority, which is often the only way to take over an unauthorized company, to stop depletion of assets, and to find assets to pay claims of victims. Federal regulators, by contrast, must go through a federal court to close an unauthorized plan or establish a receivership. Although federal actions are much slower, they can have nationwide impact—for example, when they shut down a plan that was operating in many states.

State regulators say that close coordination with federal regulators is necessary to develop evidence for a successful case against unauthorized plans. When operators of unauthorized health plans claim ERISA preemption in an attempt to avoid state regulation and delay enforcement actions, state regulators seek help from EBSA, which provides formal advisory opinions as well as informal consultations. Such advisory opinions would be helpful in every case, they say, where state jurisdiction is challenged based on ERISA. Absent such determinations, states have in some cases had to litigate ERISA challenges, a process

that can be resource-intensive, can delay closing a plan, and ultimately can hurt consumers.

But federal regulators report that their own resource constraints make timely issuance of advisory opinions difficult. To help state regulators with jurisdictional questions, EBSA updated its MEWA guide for state regulators in March 2003.²³ EBSA has also made publicly available a searchable database with information about federally registered MEWAs.²⁴ A drawback to this database is that entities seeking to avoid state oversight are not likely to register. Also, plans are not required to report financial information to the government.

RECOMMENDED REFORMS

Although many state insurance regulators and the U.S. Department of Labor have developed some effective prevention strategies, additional steps are necessary to prevent further proliferation of unauthorized health plans.

- *All states and the federal government should undertake well-funded education campaigns aimed at consumers and health insurance agents.*
- *Consumers and agents must be given the necessary tools to determine whether an entity is licensed and whether it is under investigation by a state or the federal government.* Government disclosures will help consumers and agents make informed decisions and will help stop unauthorized health plans from multiplying. One way to accomplish this is by posting open cases on government websites; when cases are closed, regulators could post the results, even if the finding is favorable to the company in question.²⁵
- *Insurance agents should receive annual training to enable them to recognize unauthorized entities.* Promoters of unauthorized plans sell their coverage through licensed agents, without whom attracting customers would be much more difficult. State regulators must therefore hold agents who violate the law accountable for their actions. Annual training should be a condition for receiving and maintaining an agent's license.

- *To stop the spread of unauthorized insurers, all states and the federal government must develop ways to identify such entities early.* Given the long history of fraud related to multiple employer welfare arrangements, the U.S. Department of Labor should not wait for patterns of consumer complaints to develop before conducting a full investigation of individual complaints.
- *State and federal regulators and investigators should share information about open cases and look for ways to better coordinate investigations.* Some of the most successful government actions have resulted from coordinated investigations.
- *Federal policymakers should clarify ERISA preemption to prevent it from being used to deflect state oversight.* Absent statutory changes to ERISA, the U.S. Department of Labor should issue more advisory opinions to help states avoid ERISA challenges. Advisory letters would greatly benefit affected consumers by allowing states to act quickly to shut down plans through administrative action, rather than going to court when challenged about their authority to shut down a plan.
- *The U.S. Department of Labor's authority should be expanded to include administrative tools, such as cease-and-desist orders, that permit immediate action.* The complementary authority of state and federal regulators has been crucial to finding and closing illegal arrangements. But regulators would benefit from additional enforcement tools to protect victims, preserve plan assets to pay medical claims, and stop unauthorized plans from proliferating. Within constitutional limits, the Department should be given authority to seize assets without first obtaining a court order, for example. Because they would preclude the need for lengthy federal court actions, these tools would help the Department close an insolvent arrangement quickly and prevent the plan's assets from disappearing. Absent such changes in federal law, only states can quickly close an unauthorized health plan.
- *States and the federal government should aggressively prosecute health plan operators who engage in criminal conduct.* Civil actions are not enough. The perpetrators may change their name, move to another state, and repeat the scam. Criminal prosecutions resulting in jail sentences would serve as a more forceful deterrent to the perpetrators of health insurance scams. To improve success rates of criminal prosecutions, state policymakers could strengthen criminal penalties by making it a felony to operate and sell unauthorized health plans. Sentencing guidelines for state judges could help ensure that operators of scams are held accountable through mandatory prison terms.
- *Federal policymakers should enact market reforms to improve access to affordable health coverage.* Expanding access to coverage, both locally and nationally, could go a long way toward stopping unauthorized plans by reducing the demand. Unauthorized health plans thrive when insurance premiums increase.
- *Insurance agents should be on the lookout for unauthorized plans.* Through due diligence—asking questions about the new company and its management, as well as verifying with the state department of insurance that the company is authorized to sell the plan in the state—insurance agents can help detect unauthorized plans. These actions could also help protect agents from potential liability for unpaid medical claims resulting from sales of such plans.

NOTES

¹ Because of their bad credit, many victims are not able to borrow money to repay providers. In many states, insurance companies are allowed to consider people's credit rating before issuing policies such as car and homeowner insurance. Thus, victims of health coverage scams are at risk of not being able to buy other insurance.

² Telephone discussion with consumer covered by the unauthorized plan (March 6, 2002).

- ³ U.S. Department of Labor, Pension and Welfare Benefits Administration, Employee Retirement Income Security Act 1999 Report to Congress, p. 15.
- ⁴ *Chao v. Graf et al.*, CV-N-01-0698-DWH-RAM, at 4 (D. Nev. Feb. 1, 2002).
- ⁵ U.S. Department of Labor, Pension and Welfare Benefits Administration, Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation 1 (1992) (hereinafter U.S. Department of Labor MEWA Guide).
- ⁶ The Labor Department now believes that it has broad authority to go after arrangements that are not ERISA covered plans when they handle ERISA plan assets, which occurs when employers covered by ERISA participate in the arrangement. U.S. Department of Labor MEWA Guide, p. 5.
- ⁷ Henry J. Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2001 Annual Survey 14 (2001) (hereinafter Kaiser Survey).
- ⁸ U.S. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO/HRD-92-40, pp. 2-3 (March 10, 1992) (hereinafter 1992 GAO Report).
- ⁹ In 1991, the GAO told Congress that the U.S. Department of Labor needs to issue regulations clarifying union status. 1992 GAO Report, p. 9.
- ¹⁰ U.S. Department of Labor, Pension and Welfare Benefits Administration, Employee Retirement Income Security Act 1998 Report to Congress 8 (hereinafter 1998 Report to Congress). See also "Court Grants Preliminary Injunction, Continuing Freeze of Assets of Trustees and Administrator of New York-Based Health Program" (press release), U.S. Department of Labor, Pension and Welfare Benefits Administration, December 29, 1998.
- ¹¹ Procedures for Administrative Hearings Regarding Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA, 68 Fed. Reg. 17472 (April 9, 2003) (to be codified at 29 C.R.F. part 2510 and 2570).
- ¹² Procedures for Administrative Hearings Regarding Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA, 68 Fed. Reg. p. 17475.
- ¹³ Aissatou Sidime, "Health Insurance Rip-offs Rising," *San Antonio Express-News*, March 19, 2002, p. 3E. For information about state cease-and-desist orders, see Mila Kofman, Kevin Lucia, and Eliza Bangit, "Proliferation of Phony Health Insurance: States and the Federal Government Respond," *BNA PLUS* (August 2003).
- ¹⁴ Discussion with lawyer who was supervisor of unauthorized entities in a state insurance department (April 17, 2003).
- ¹⁵ U.S. Department of Labor, Employee Benefits Security Administration, Fact Sheet: MEWA Enforcement (December 2002).
- ¹⁶ Kaiser Survey, p. 16.
- ¹⁷ Projected by Hewitt Health Value Initiative, Hewitt Associates, *Annual Health Care Cost Increases National Averages* (2001).
- ¹⁸ California's public employees benefits program estimates a premium increase of 20 to 25 percent. CalPERS, *2003 Health Plan and Premium Changes*, available at www.calpers.ca.gov (April 17, 2002). A UCLA study estimates private premiums to increase by 20 percent in 2003. "Health Insurance: Premiums Expected to Rise 20% in 2003," *American Health Line* (June 18, 2002).
- ¹⁹ InfoSearch International, *Unauthorized Insurance Awareness Study*, p. 4 (February 2003) (Report for the Nevada Department of Insurance).
- ²⁰ Discussions with two state insurance department officials (January 21, 2003).
- ²¹ Education also encourages agents to be more diligent in fully checking the products they sell to consumers.
- ²² NAIC Reporting Requirements for Licensees Seeking to Do Business with Certain Unauthorized Multiple Employer Welfare Arrangement (MEWAs) Model Regulation.
- ²³ An updated MEWA guide is available at <http://www.dol.gov/ebsa/publications/main.html>.
- ²⁴ Database available at <http://www.askebsa.dol.gov/epds>.
- ²⁵ The U.S. Department of Labor should make its voluntary compliance letters (an agreement by the company to correct potential violations) available to the public via its website.

ABOUT THIS STUDY

For our examination of federal and state strategies to combat health insurance scams, we consulted with the National Association of Insurance Commissioners and with state regulators who are recognized leaders in addressing the problem. We focused on states that have had many victims of insurance fraud, as well as those in which regulators have aggressively pursued unauthorized operators. We also looked at states where the problem is just emerging. We interviewed state insurance commissioners, insurance regulators, investigators (civil and criminal), and legal counsel from Arkansas, California, Colorado, Florida, Indiana, Louisiana, Texas, and Wisconsin.

To include the federal perspective, we interviewed regulators and investigators from the U.S. Department of Labor, including the Employee Benefits Security Administration (EBSA) and the Inspector General's Office. EBSA is responsible for ERISA oversight and is the primary federal investigator of unauthorized health plans. The Inspector General investigates phony unions. In addition, we interviewed a local prosecutor specializing in insurance litigation, court-appointed receivers and their attorneys for the two largest unauthorized plans closed by state and federal government, insurance agents who have been solicited to sell unauthorized coverage, current and former FBI agents with experience in insurance fraud, and a litigator from a state attorney general's office who worked on MEWA cases in the early 1990s.

Copies of the full report, Proliferation of Phony Health Insurance: States and the Federal Government Respond, are available from BNA PLUS. To order, call 800-452-7773 or 202-452-4323, fax 202-452-4644, or e-mail bnaplus@bna.com.

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QUESTIONS SUBMITTED BY CHAIRMAN GRASSLEY

Q: In your testimony you note that the “DOL needs to issue timely advisory opinions when a state needs help to avoid ERISA challenges to state authority by promoters of scams.” Can you explain further the role of DOL’s advisory opinions and insurance scams.

The U.S. Department of Labor (DOL) through the Employee Benefits Security Administration (EBSA) has authority to issue formal advisory opinions and informational letters on the legal status of an arrangement. A written opinion from the federal government makes it easier for a state to assert authority over an arrangement falsely claiming exemption from state authority under ERISA. For example, EBSA issued a written opinion to the insurance departments in Arkansas and Texas regarding their jurisdiction over UEVEBA, an entity related to American Benefit Plans claiming ERISA preemption.¹ UEVEBA and American Benefit Plans left 40,000 consumers nationwide with over \$40 million in unpaid medical bills. EBSA evaluated the structure of UEVEBA and determined that ERISA did not preempt state regulation. This letter served as green light for state regulators to complete their administrative actions. The letter also helped the Texas Insurance Department when operators of the entity claimed ERISA preemption in state court, attempting to prevent the Insurance Department from seizing assets. And when operators of UEVEBA removed the state case to federal court, again it was helpful for the state to have a letter from the federal government on the legal status of UEVEBA – stating that ERISA did not prohibit state action.

Research shows that state regulators believe that written opinions from DOL would be helpful in every case when state jurisdiction is challenged based on ERISA.² Absent such determinations, in some cases, states have to litigate ERISA challenges, which is both resource intensive and results in a delay in closing the arrangement. Delays ultimately hurt consumers as discussed in the written testimony. The federal government cannot act as quickly as states to shut down a scam. So, if a state’s hands are tied because of ERISA, then consumers pay the price -- paying premiums to a phony company and incurring more medical bills.

¹ U.S. DEPARTMENT OF LABOR, PENSION AND WELFARE BENEFITS ADMINISTRATION, Informational Letter to Jose Montemayor, Commissioner of Insurance, Texas Insurance Department, Mar. 18, 2002.

² Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond*, BNA Plus (2003).

When a state seeks help from DOL, the federal government should be required to issue a formal letter in a timely manner to assist the state. This will greatly help address the current problem of health insurance scams.

Q: It is apparent that one of the keys to success with these scam insurances is an aggressive education campaign. Would you please share with me your thoughts on how we, in the federal government, could be more aggressive in PREVENTING people from falling victim to these scam artists?

Educating the public about phony insurance is a way to prevent consumers from becoming victims. Several states, e.g., Nevada, have launched education campaigns that include radio, television, and magazine/newspaper advertisements warning consumers about phony insurance. Importantly, these states are not relying on public service announcements (PSAs) alone to get the message out – when picked up by the media, PSAs may appear in the middle of the night doing little good for most consumers, who are not awake to see them. Instead, these states are paying for professionally produced ads and a strategic media campaign to educate the public.

The federal government should launch a paid media campaign to educate consumers. This is a national problem that needs national attention and federal funding. One way to implement an effective, national education campaign would be to partner with states or with the National Association of Insurance Commissioners (NAIC) to develop state-specific ads. To be effective, a consumer education campaign must address local state conditions and provide consumers with a resource tool -- the local number of the state insurance department. By calling the state's insurance department, consumers are able to verify that an insurance arrangement is authorized to sell health insurance. The federal government does not license ERISA plans, therefore consumers should not call DOL to learn whether a company is licensed. It is essential for media ads to give consumers a number to the state insurance department. A media campaign funded by the federal government that points consumers to resources available in their state would be an effective way to empower consumers and prevent some from falling victim to health insurance scams.

QUESTIONS SUBMITTED BY SENATOR BAUCUS

Q: During her testimony, the Assistant Secretary of the Department of Labor (DOL) stated that pending federal legislation, which would allow for federal licensing of Association Health Plans (AHPs), would help DOL know who is operating and therefore DOL could better protect consumers. Do you agree?

No. DOL does not need to license associations, a type of multiple employer arrangement, to know who is operating. In 1996 Congress gave DOL authority to require multiple employer arrangements to register with DOL. This was in response to a long history of health insurance scams promoted through such arrangements and insolvency of legitimate arrangements. As a result of this 1996 congressional action, DOL requires multiple employer arrangements to register.

So in theory, DOL already ought to know who is operating. In practice, unfortunately, there is no evidence that DOL is enforcing the registration requirement or is even reviewing the filings.

For example, based on a review of registration forms filed with DOL in 2003, out of some 700 filings, over 100 forms had significant problems including claims that such entities were licensed by the states when in fact they were not. DOL is authorized to fine such arrangements up to \$1000 per day for submitting incomplete or inaccurate filings. To date, there have been no enforcement actions.

In a review of association health plan insolvencies of the last three years, we found the following:

- In 2001, an association plan (NJ Car Retailers) notified DOL that it was not complying with ERISA's requirements and even submitted a copy of court documents detailing its non-compliance. In 2002, a court appointed receiver notified DOL that the association health plan was insolvent. Had DOL reviewed the initial filing and investigated the association health plan's non compliance, perhaps DOL could have prevented the insolvency or at least mitigated its effects. The insolvency left 20,000 people without health insurance and with \$15 million in unpaid medical claims.
- In 2001, another self-insured association health plan (Indiana Construction Industry Trust) notified DOL that it had doubled in size in one year (based on comparing its 2000 and 2001 filing). This should have been a red flag for federal regulators about a potential problem – a self-insured association that doubles in size may have solvency problems due to its rapid growth. Had DOL examined the filing, perhaps it could have prevented this association from becoming insolvent a year later. This insolvency left 22,000 people with \$20 million in medical bills.

Additional responsibilities under the proposed AHP licensing legislation will not help DOL be better regulators. Perhaps additional resources would help DOL do a better job with their current responsibilities.

Q. Do you think that the AHP legislation will help address the problem of phony health insurance?

No. The AHP bill will do just the opposite. It would put DOL in charge of an area that is currently regulated by both the federal government and states. And by putting DOL in charge, it would prohibit states from helping consumers. This is bad news for consumers and good news for criminals for a number of reasons.

First, DOL's record on shutting down scams is weak especially compared to states. As the GAO points out, while states have issued cease and desist orders against 41 arrangements, DOL was able to shut down only 3 entities. When DOL investigates both a criminal and a civil case, it means that at least two investigators must be assigned. This is because of constitutional due

process rights of a criminal defendant. One person cannot investigate both a criminal and a civil case. DOL's resource constraints means that a scam may only be investigated civilly or criminally. Both civil and criminal actions, however, are necessary to protect consumers. A civil action allows government to shut down a scam and to try to find assets to pay outstanding medical bills. A successful criminal action allows government to put perpetrators of fraud in jail -- the only way to stop them from repeating the scam. Preempting states from civilly and criminally investigating health insurance scams would only hurt consumers.

Second, the legislation does not give DOL new enforcement tools, the type of administrative authority that states have to shut down scams quickly. It can take DOL about two years to shut down an arrangement (see discussion on TRG in written testimony) compared to quick actions by states -- weeks in some cases and months in most cases. Time is critical because operators of scams move, hide, or spend assets quickly. DOL cannot adequately protect consumers in part because of its pace in investigating these cases. To preempt state efforts is bad for consumers.

Third, the AHP bill creates new preemption ambiguities in ERISA. It's like turning back the clock to pre-1983. In the early 1980s, Congress stepped in to fix the problem of rampant fraud and insolvencies of multiple employer arrangements when DOL was the only regulator, not able to effectively regulate (see written testimony). Congress clarified ERISA to say that both states and DOL have authority to regulate multiple employer arrangements. Although there is still some ambiguity of which promoters of phony health plans take advantage, the amendment to ERISA in the early 1980s worked to better protect consumers with both states and the federal government having oversight. This bill would turn back the clock and preempt states once again. The new ambiguity in ERISA will give criminals the excuse they need to once again claim exemption from state oversight even when they are not licensed as AHPs. Additionally, due to the new preemption standard in the legislation, states would be powerless to stop phony insurance companies from selling coverage to licensed AHPs. Congress has already experimented with this before, when DOL was the primary regulator, and the result was a disaster -- lots of fraud and insolvency. The AHP bill would make things worse for consumers who now more than ever need state insurance department intervention and quick state action to shut down scams.

This is the wrong time to pass a bill that has the potential of increasing fraud (and insolvency).

QUESTIONS SUBMITTED BY SENATOR KERRY

Q: You recommended that DOL be given cease and desist authority without having to seek a court order. Could you expand on how such authority might work, and how it would complement state authority? What changes in current DOL staffing and operating procedures would be required if it were given cease and desist authority?

Similar to states' cease and desist (C & D) authority, the federal government's authority should be expanded to include C & D orders. C & D authority allows state regulators through administrative action to shut down health insurance scams. Because it is an administrative action, not a court action, it is quicker than going through a court proceeding. Such actions may

require less evidence than a court requires and the rules of evidence are not as strict (evidence inadmissible in court could be used in an administrative proceeding). Quick administrative actions at the state level have been one of the most effective tools available to state regulators to stop health insurance scams.

The U.S. Department of Labor does not have cease and desist authority or similar administrative authority. To close an arrangement, the Department must file a lawsuit in federal court. It must seek a temporary restraining order (TRO) and a preliminary injunction (PI) from a federal court. A TRO and PI by a federal court require the federal government to offer sufficient evidence at a pre-trial hearing to prove that a violation of ERISA has occurred and to demonstrate that the government will probably prevail on the merits once the case is fully litigated. Unlike states shutting down unauthorized arrangements based on a failure to be licensed, the federal government must prove a violation of a fiduciary duty, which is financial in nature requiring evidence that assets have been misused. To gather enough evidence for a successful hearing in federal court, depending on the nature of a case and ability to obtain records, Labor's investigations may take several years. While being investigated, operators of scams continue collecting premiums without paying claims.

Cease and desist authority at the federal level would help DOL shut down scams quickly (by avoiding a court action) and would help consumers nationally. State actions are only effective within a state's borders. When a phony company operates nationally, to shut it down, every state would have to issue a C & D order.

Congress should amend ERISA to give DOL additional administrative enforcement tools. One option is to allow DOL to issue a federal C & D order in cases involving MEWAs. This would require an administrative proceeding perhaps with an administrative law judge at the federal level. Because time is of the essence in cases involving health insurance scams -- assets disappear quickly -- to expedite a potentially lengthy administrative proceeding (although it would still be quicker than a court proceeding), Congress could establish a presumption that allows DOL to issue an order based on a state action (especially if Congress were to amend ERISA to make it a per se violation of ERISA for a MEWA to operate without an appropriate state license). So for example, if a state shut down a MEWA for operating without a license, DOL would base its administrative order on the state action. The arrangement, however, would still have due process and be given an opportunity to rebut the presumption.

DOL's administrative order would have national impact. This approach would result in a better use of resources than having each state issue its own C & D order. And more importantly, this approach would better protect consumers.

In the alternative, if Congress does not expand DOL's administrative authority, then Congress should change the burden of proof that DOL has in federal court. As discussed earlier, to shut down a health insurance scam DOL must prove violations of ERISA, which are financial in nature, and take considerable time to investigate. Congress could amend ERISA to make it a violation of ERISA for a MEWA to operate without a proper state insurance license (unless the state does not require it to have an insurance license, e.g., it is fully insured). This would allow DOL in cases involving a MEWA to show in federal court that an arrangement is operating

without a state insurance license. That fact is easy to verify with a state and easy to prove. If an arrangement claims that it is exempt from state insurance laws because of ERISA, then it would have an opportunity to demonstrate why it is exempt. If a federal court finds that the arrangement is not exempt from state insurance law under ERISA and is operating without a state license, then the federal judge could order it to cease operations. Allowing DOL to go to federal court when a MEWA is operating without a proper state license would greatly help shut down health insurance scams quickly. And, federal court actions have national impact and would benefit consumers in every state.

DOL may need additional resources for either administrative proceedings or federal court actions.

Q: You also recommend a number of other Congressional actions to clarify ERISA and DOL's enforcement of it. Since this is now the third round of insurance scams the country has experienced, what have been the barriers to changing current legislation and regulation to close the ERISA exemption loopholes now used by most insurance scams at such great cost to individuals and companies that fall prey to these operators and to the health care system overall.

Congressional response to the first wave of scams, which occurred after ERISA was enacted in 1974, has been helpful. In response to health insurance scams -- an unintended consequence of ERISA -- in 1982 (effective 1983) the U.S. Congress amended ERISA to clarify that states could regulate multiple employer arrangements called MEWAs (multiple employer welfare arrangements) even if such arrangements could meet the requirements of an ERISA plan. The clarification removed an ambiguity of which fraudulent operators had taken advantage. This made it possible for states to take more aggressive actions against phony health plans trying to hide behind the ERISA shield. There is still some ambiguity in ERISA, e.g., what is a collectively bargained union plan exempt from state insurance regulation. Unfortunately, although the 1983 amendments greatly improved the government's ability to help consumers, promoters of phony health insurance continue to use ERISA and its ambiguities as a shield against state oversight.

In addition to the ERISA problem, in recent years premiums for health insurance have increased in the double digits. Consumers are desperate for affordable alternatives. It is difficult to find comprehensive coverage at an affordable price. And that creates opportunities for criminals to take advantage of desperate consumers looking for affordable health insurance. A clear solution is to strengthen existing safety-net programs and to enact laws that will enable people and businesses to find affordable health insurance. Take away the demand, and there will be a drop in supply of illegal health plans. Absent comprehensive reforms, Congress could and should enact new laws to help victims of phony health plans who are stuck with thousands of dollars in unpaid medical bills.

To better protect consumers against health insurance scams, federal policymakers and regulators could take immediate, specific actions to slow the spread of health insurance scams and to help the victims of these scams.

- Public awareness can help prevent the spread of health insurance scams. To that end, Congress should allocate resources and require the U.S. Department of Labor to undertake a nationwide consumer education campaign. As discussed earlier, an education campaign must advise consumers to check with the state insurance department to ensure that the company they are buying insurance from is authorized in their state.
- Congress could clarify ERISA to prevent it from being used as a shield against state oversight. Amending ERISA to prohibit MEWAs from removing cases from state to federal court would greatly help reduce delay tactics used by operators of phony plans and would help minimize using ERISA as a shield. In the alternative, Congress could make it more difficult to remove such cases to federal court.
- Currently, DOL's policy is to initiate an investigation when there is a discernable pattern of ERISA violations — more than one consumer with unpaid claims. Given the long history of fraud related to MEWAs, federal regulators should not rely on patterns before fully investigating complaints. Instead such investigations should be automatic after receiving information from a single consumer calling with the problem of unpaid medical claims by a MEWA. Waiting for a pattern of unpaid bills is unfortunately too late to be of real help to victims.
- When consumers suspect a problem and call the federal government, it is DOL's policy not to inform the public about an investigation. So, consumers have no way of knowing that there is a potential problem and it takes years for DOL to go to court (and that's when the public finds out about the problem). Consumers continue paying premiums and continue to incur medical bills. DOL should disclose whether a MEWA is being investigated. And if the investigation is closed because there is no wrongdoing, then DOL could also inform the public of that. Such information could help consumers make better decisions. This would help improve efforts by the federal government to prevent proliferation of unauthorized health plans.
- As discussed earlier, Congress could require the U.S. Department of Labor to issue timely advisory opinions when a state needs help to avoid ERISA challenges to state authority by promoters of scams. Advisory letters would also greatly benefit affected consumers by allowing states to take quick action without being forced to defend their jurisdiction when challenged on ERISA preemption grounds.
- Congress could amend ERISA to give the U.S. Department of Labor new enforcement tools such as cease and desist authority (as discussed earlier). This would help augment current state authority and empower federal regulators to be more effective. In the alternative, Congress could amend ERISA to make it a violation of ERISA for MEWAs to operate without a proper license from a state. This would allow federal regulators to shut down health insurance scams more quickly and would allow DOL to avoid lengthy actions in federal court that require evidence of financial violations of ERISA. Quick action is critical to protect victims by preventing assets from disappearing and stopping the phony plan from proliferating.

- Congress could require the U.S. Department of Justice to establish a task force to focus on health insurance scams. The task force should include state and federal regulators, as well as people from the law enforcement community including the FBI, the U.S. Postal Inspector, the U.S. DOL's Inspector General, the IRS, and the U.S. Attorneys office. Some of the most successful cases have resulted from coordination and sharing of information.³ That's essential to finding and closing illegal operators. An on-going task force would facilitate better information sharing and perhaps result in quicker actions.
- Congress could help victims of fraud by establishing a special fund to help pay medical bills that should have been paid by the phony company. This federal fund could be funded with civil penalties that the federal government obtains against perpetrators of health insurance scams. For example, civil penalties are recovered by the Internal Revenue Service when perpetrators of health insurance scams file improper tax returns (or fail to report income). Congress could require such civil monetary penalties to be made available to pay medical bills of victims. This could help many small businesses and workers avoid bankruptcy, and in some cases continue to receive medical care from providers.

In addition, even if the federal government makes these suggested improvements to its oversight and regulation efforts, civil actions do not stop those who engage in criminal conduct. Their response to civil actions is to change their name, move to another state, and repeat the scam. More criminal court actions are necessary to stop perpetrators and to hold them accountable. To that end, the federal government should be more aggressive with criminal prosecutions. Congress should require the Justice Department to pursue more aggressively cases against promoters of phony health insurance.

These actions by Congress and DOL could make a significant difference in preventing health insurance scams, stopping such scams quickly, and better protecting consumers.

³ See discussion about coordinated cases in Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond*, BNA Plus (2003).

**TESTIMONY BEFORE THE
UNITED STATES SENATE
COMMITTEE ON FINANCE**

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MARCH 3, 2004

José Montemayor
Texas Insurance Commissioner

Good morning Mr. Chairman and members of the Committee. I am pleased to have this opportunity to discuss with you the very serious problems that health insurance scams pose in Texas and across the country. My name is José Montemayor, and I have held the position of Commissioner of Insurance for the State of Texas since 1999. I am here today seeking your assistance to put a stop to a growing and dangerous problem, unauthorized insurance scams. My department faces a constant onslaught of phony ERISA plans, and my staff receives phone calls and inquiries daily, almost always asking us the same question - who is going to pay the claims left behind by these phony, defunct health plans? Unfortunately, we usually don't have an answer for these questions. Frankly, we're tired of that, and we are seeking your assistance to put a stop to this.

I want to stress from the outset that the current problem is not that the states cannot stop illegal ERISA plans from operating in their jurisdictions. It is that the shield of a potential exemption from state regulation under ERISA currently creates the opportunity for scams to operate for significant periods of time before they are recognized as illegal and before formal action can be taken against them. In Texas, we have the authority to shut down these scams, and we do stop them, but we normally cannot do so until after they have already done a great deal of damage to the public. In Texas, we have issued cease and desist orders against these plans, ordered millions of dollars in penalties against the operators, and we have taken action against those who have sold the plans. In 2003, for instance, I issued over 100 orders against licensed insurance agents who sold unauthorized insurance, ordering them to pay the unpaid

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claims – but the salesmen often do not have the money to pay all of the claims. A number of them have declared bankruptcy.

I also want you to know that this problem is not just a matter of a few people being out of some money or a few doctors not getting paid. When these phony plans go under, we get calls from people who are placed in truly desperate circumstances. Here are a few examples. My staff got a call one day from a pregnant woman, due to deliver soon, whose doctors wouldn't see her any more because her insurance, provided to her by her employer, was fake. Kathy Mahan is a specific victim who comes to my mind. She lives in Houston, Texas. She tells us that when she arrived at the hospital for surgery to remove a tumor in her brain, she was told that her surgery had been cancelled because of questions about her health insurance. Though she eventually got the operation, the delay had a negative impact on her health, and now her doctors will not see her for the necessary follow-up treatments because their bills have not been paid. Even worse, Mrs. Mahan's husband, Gerard, also had an operation during this same time period, and his bills have also not been paid, and his doctors won't see him any more. People like this are often forced into bankruptcy through no fault of their own. In many cases, the small business employers who provided them this insurance are also forced out of business when they become liable for the claims of their employees.

Almost every unauthorized plan is a variation on a common theme – a claim of federal exemption from state regulation under the ERISA act. While I certainly recognize ERISA's value to businesses that can afford to self-fund their insurance, almost every illegal health insurance plan we have dealt with began with someone

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putting together a set of glossy plan documents which contained some statement, however flimsy, that the plan wasn't regulated by the states. Most of these scams have common elements and run the same course, but they are usually doomed from the beginning. They are usually run by people who are experienced in the industry, often by people who have been involved in prior phony ERISA plans that failed. They try to get as many enrollees as possible, as fast as possible, through low rates and little underwriting, skim as much money off as fast as they can, and then walk away. These people know that they are going to leave unpaid claims, and the more successful they are at marketing the plan on the front end, the more unpaid claims there will be. And these scam artists know that people can die because of their actions.

The biggest unauthorized plan in recent years, Employers Mutual, with 7200 Texas residents enrolled, was perhaps the boldest in this regard. The creators of that plan simply asserted ERISA status with no attempt to explain why. They enrolled virtually anyone who applied. One of their only underwriting guidelines was a request that sales not be made to people already in the hospital. We have now received almost 500 complaints against that company.

Perhaps the second biggest unauthorized plan nationally, American Benefit Plans, at least made up something to support its claimed exemption. It asserted that employers could band together to form what were called "Voluntary Employees Beneficiary Association" or "VEBA" trusts that would be tax-exempt under Section 501(c)(9) of the Internal Revenue Code. From that, they went on to boldly, and falsely, argue that the plan would be exempt from state insurance regulation through the interplay of the tax code and ERISA. Of course, there was no legal basis for such an

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argument. Because that plan was based in Texas and we were able to locate many of its assets, we went to court and took it over. We are now sorting out the mess that it left behind.

Probably the third biggest unauthorized plan, known as TRG, had yet another false theory for ERISA exemption – they asserted that anyone could purchase the TRG insurance by becoming nominal employees of TRG and then participating in TRG's own purported "single employer" health plan, exempt from state insurance laws. TRG never paid anyone for their employment, and enrollees did not have to actually do any work for TRG (aside from signing their insurance application).

Another plan, Privilege Care, had a two-part basis for its alleged exemption. It falsely asserted that it could, as a staff leasing company, act as a single employer under ERISA for the groups that signed up under it, but then it did not even obtain a staff leasing license, and it failed to actually operate as a true staff leasing company. It also asserted that it had negotiated a collective bargaining agreement with a union - the Professional and Industrial Trade Workers Union. However, it turned out that none of the people receiving insurance benefits had any idea that they had been unionized. We've gotten almost 200 complaints on that plan so far.

In each of these cases, the perpetrators needed only the barest argument for exemption from state licensing requirements in order to start enrolling mass numbers of people who thought they were getting a great deal on health insurance. Many state departments of insurance were unaware of these plans until the complaints started coming in, and even then it took time to prove that the plans were operating as non-exempt multiple employer plans rather than as exempt single employer plans. Further,

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the Department of Labor generally took the position that such plans had some element of ERISA status, and it was certainly not in a position, when consumers called, to quickly opine on whether the plans were subject to state regulation. As with typical ponzi schemes, as long as the numbers were quickly increasing, these plans could continue to pay claims. The plans then started stonewalling on the larger claims as long as they could before either getting shut down by regulators or simply walking away.

With these issues in mind, I would like to take this opportunity to point out some items that I would like the Committee to consider that I believe would be helpful in remedying the problem.

I would request that the Committee consider expanding the powers of the Department of Labor to take action against illegal ERISA plans. Currently, it appears that the DOL must generally prove a breach of fiduciary duty or fraud in order to take civil or criminal action against an ERISA plan or its operators. This is a far cry from the resources the states have in regulating the rest of the insurance industry. In Texas, we take over insurers when we can merely show that the insurer is either insolvent or hazardous to the public. Because it is so much easier to demonstrate that a plan is insolvent than it is to demonstrate that fiduciary duties have been breached, the DOL should be given similar authority to take over ERISA plans. It should always be remembered that ERISA health plans have no statutory requirements to maintain reserves to pay their claims and that there are no guaranty fund protections for the participants enrolled in self-funded ERISA plans, making it even more important that federal regulators be able to take quick action to either rehabilitate or stop plans that are in financial trouble.

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The DOL should also be given the authority to issue preliminary cease and desist orders against plans that are in financially hazardous positions or are otherwise violating federal law, at least to the extent of being able to prevent such plans from continuing to enroll new victims.

Also, I would point out that, though the Department of Labor shares regulatory authority over MEWAs with the states, there does not appear to be any specific federal criminal or civil penalty for falsely representing a plan to be exempt from state regulatory authority. There are penalties for impersonating a lawyer or a doctor. Why should a scam artist be able to represent to the unsuspecting public that his plan is exempt from state regulation when it is not. I believe that these perpetrators need additional deterrence from making such misrepresentations.

As I mentioned previously, one of the factors that allows the quick growth of unauthorized plans is the inability of employers and consumers to check on the legality of the plans in which they are being enrolled. In Texas, it is a simple process to check our website or to call our 1-800 telephone line to confirm the licensure of an insurance company or agent. There is nothing similar in the ERISA context. In fact, most ERISA plans are not required to file any documentation regarding their plans or even their existence, until they file their Form 5500s, seven months after the end of their first plan year. Even plans that admit they are MEWAs (which most scams do not) are not required to file their MEWA reporting forms until three months after they make their first sales. This allows many fraudulent operators to truthfully tell consumers that there is no agency to call to check on the legality of the plan and that they are not required to have anything on file with any regulatory authority. Why should ERISA plans, in whom so

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many are placing their money and their trust, not be required to make some kind of initial filing in order to put the Department of Labor, and inquiring state regulators, on notice that they are in existence? I recommend that ERISA plans be required to make such a preliminary filing, disclosing, for instance, who will be operating the plan, who will be insured by the plan, and what backing insurance the plan will have.

Related to this are the means that are available to the states to investigate MEWAs. Currently, the purported ERISA plans that we are investigating to determine MEWA status often refuse to provide us any information on the basis that even the authority to investigate whether we have jurisdiction over a plan is pre-empted by ERISA. The states must be given explicit authority to subpoena jurisdictional information from ERISA plans. Additionally, while there is currently a very good system for informally sharing information and documents between state and federal investigators, this tends to break down when it comes time to formally use that information or documentation at state hearings. Often Department of Labor investigators are limited in their ability to testify in state proceedings against MEWAs because of privacy or criminal investigative concerns. I believe that a provision explicitly permitting such investigators to testify and produce documents in state proceedings would greatly increase the speed and effectiveness of our state proceedings in shutting down unauthorized plans.

Another issue that has been presented in a number of cases is the argument that ERISA plans can obtain backing in the form of stop loss insurance from any company they want and in whatever form they want, and the states cannot regulate that insurance in any way because it is "reinsurance" between two "insurers." The

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perpetrators falsely assert, for instance, that they may purchase the equivalent of first-dollar health insurance coverage from unlicensed insurance companies without their plan being considered a MEWA and without the states being able to regulate the so-called "reinsurer" in any way. I recommend clarifying that states are not pre-empted from regulating the insurance purchased by ERISA plans.

Again, I appreciate the Committee allowing me to appear today to discuss these very important issues. I would be happy to answer any questions the Committee might have.

RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

Question 1. How are most illegal health plans first identified?

Answer. The Department of Insurance becomes aware of illegal plans in a number of different ways. For example, the National Association of Insurance Commissioners has a working group devoted to illegal multiple employer welfare arrangements (MEWAs). Through that working group, regulators can, by e-mail, quickly spread word of a new multi-state plan which has been discovered in one state. Additionally, licensed insurance agents who have lost business to, or been solicited to sell, illegal plans often bring them to our attention. Also, when the plans begin to stop paying claims, consumers will often complain to the Department despite the fact that the plan was represented to be exempt from state regulation. From such complaints, it often becomes apparent that the plan involved the co-mingling of assets as a MEWA rather than as truly exempt individual employer plans. Another useful tool is the practice of the Department of Labor in making MEWA Form M-1s which are filed annually with that Department, available on the web. See www.askebsa.dol.gov/epds. While many illegal plans do not file that form because they deny that they are MEWAs, it is relatively easy to identify likely illegal MEWAs from those forms which are filed.

Question 2. What state resources are devoted to the shutting down of illegal health plans?

Answer. On the civil side, the Texas Department of Insurance created an Unauthorized Insurance Team in 2002 to focus on all types of unauthorized insurance, including health insurance. It currently has 12 attorneys and 9 investigators working on such cases to varying degrees. If litigation against a plan moves to state or federal district court, the Texas Attorney General represents the Department. On the criminal side, the Department's Fraud Unit investigates matters related to illegal health plans for referral to state or federal prosecutors.

Question 3. How long does it typically take your state to shut down a plan once it is identified?

Answer. This can vary widely depending on the complexity of the case (proving that different employers' funds are co-mingled, for instance), available resources, and the cooperation of the operators. Some unauthorized insurance plans have voluntarily issued notices of termination very soon after initially being contacted by the Department. Other plans have terminated after being issued emergency cease and desist orders. Such orders have been issued in as little as three months after identification, but can also take more than a year. On average, it probably takes about six months to shut down an illegal plan.

Question 4. In your testimony you state that "ERISA" currently creates the opportunity for scams to operate for significant periods of time before they are recognized as illegal and before formal actions can be taken against them? Can you please expand on this statement and tell us what you see as a solution?

Answer. It is my understanding that ERISA Form 5500 Annual Returns, which are required of most ERISA plans, are not required to be filed until seven months after the end of their first plan year. See www.dol.gov/ebsa/pdf/rldguide.pdf. If a plan admits that it is a MEWA, or otherwise claims that it is ERISA exempt despite covering multiple employer groups, it is generally required to file the Form M-1 Report by March 15 of the following calendar year, or within three months of an "origination." The primary objection to such a system is that fraudulent operators can truthfully tell consumers that they were not required to get any regulator's approval, or even file any plan documents, before commencing operations. The lack of an advance filing requirement allows some scam operators to operate for a minimum three months without having to file anything. Then, they merely need to assert that they are operating single employer plans in order to avoid filing anything for another sixteen months. Even if the DOL commenced an investigation immediately at that point based upon the failure to file, it would likely still take many months for it to develop a sufficient case to shut the illegal plan down. Further, even if a plan does make its filing, there is nothing equivalent to the state system where a consumer can readily find out if a company or agent has been approved to do business in the state. ERISA plans are generally for larger employers, why shouldn't those types of plans, in whom so many place their money and their trust, be required to make some kind of initial filing with the Department of Labor and their domiciliary states to at least put regulators on notice of their existence? I recommend that all self-funded ERISA plans be required to make preliminary notice filings with the DOL and the states in which they will operate, disclosing who will be sponsoring the plan, who will be administering it, who is anticipated to be insured by the plan, and what backing insurance the plan will have, if any, prior to signing up the first employer.

Question 5. What does the state do to help the victims of fraudulent plans?

Answer. The Department of Insurance regularly takes action against the operators of illegal plans and against those who sell illegal plans in order to try to obtain restitution to victims. For instance, since September 1, 2003, the Department has issued 72 orders against insurance agents for selling unauthorized health insurance plans. Each order required the agent to pay the unpaid claims of the victims. Where the plan was based in Texas and there appeared to be the ability to seize assets, Texas has placed the plan under the same kind of court supervision which the Department of Labor utilizes in order to distribute plan assets fairly. Texas also pursues criminal cases against the operators of fraudulent plans, which could also result in orders for restitution.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR KERRY

Question 1. In the GAO report, Texas had the distinction of having the highest number of insurance scams, a total of 31. What makes Texas such fertile ground for these illegal operators?

Answer. Texas is no more fertile ground for illegal operations than other states. Texas is; however, a leader in enforcement, taking swift actions whenever these plans are encountered. Since 2001, Texas has been one of the most aggressive states in identifying and fighting unauthorized health insurance plans. Rather than simply acting on complaints filed after the plan has become insolvent, Department staff watch for new plans. For instance, staff tracks what is being offered to victims of prior scams. Through such proactive approaches, the Department has identified a large number of small plans and shut them down before they had a chance to become larger problems. Additionally, however, Texas has been the victim of the combination of a number of market factors—Texas businesses were hard hit by the recession and a large increase in medical care and health insurance costs. Adding these factors to a high number of uninsured in the state, Texas was a ripe target for marketers of the scams. Both employers and individuals were looking for ways to be able to afford health insurance, and these schemes offered an easy way to do it. Texas' numbers will likely stay high as staff continue to try to identify small plans early on. For instance, a number of files have already been opened based upon the recent filed ERISA Form M-1 reports.

Question 2. In your testimony you make a number of suggestions for new authorities that could strengthen the ability of states to shut down insurance scams claiming ERISA exemption. Are you pursuing the implementation of these ideas with DOL, NAIC, and within your own state? What are the barriers to implementation, and how might they be overcome?

Answer. The suggestions made in the testimony would require action on the federal level to amend the ERISA statute. The suggestions would not reduce the exemption of legitimate ERISA plans from state regulation but only increase the ability of the Department of Labor to regulate ERISA plans and the ability of the states to identify and regulate illegal plans. Nevertheless, resistance to such suggestions is to be expected. The NAIC has a working group devoted to MEWA issues, and that group is working to more fully develop proposals flowing from the ideas presented at the Senate Finance hearing. State legislation which would also make ERISA preemption issues clearer is likely to be pursued.

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**TESTIMONY
OF THE
NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS**

**BEFORE THE
SENATE FINANCE COMMITTEE**

**ON
The Effect of Unauthorized Benefit Plans
on Employers and Individuals**

Presented by:

**Fred Nepple
General Counsel
Wisconsin Office of the Commissioner of Insurance**

March 3, 2004

Introduction

Good morning Mr. Chairman and members of the Committee. My name is Fred Nepple and I am General Counsel for the Wisconsin Office of the Commissioner of Insurance. I am also Chair of the National Association of Insurance Commissioners (NAIC) ERISA Working Group. It is in this capacity that I come before you today to discuss the NAIC's efforts to assist in the identification, elimination and prosecution of unauthorized health plans.

The NAIC represents the chief insurance regulators from the 50 states, the District of Columbia, and four U.S. territories. The primary objective of insurance regulators is to protect consumers. It is in furtherance of this goal that the NAIC has implemented several aggressive efforts to address the growing problem of unauthorized health plans.

The Problem

Unauthorized health plans that claim to provide comprehensive coverage at premiums a fraction of those charged by state licensed insurers seem like a dream to many employers and individuals struggling to afford or even obtain coverage. Unfortunately, the dream quickly becomes a nightmare.

Unauthorized health plans have had a destructive ripple effect, impacting every aspect of the health care system. Individuals and families, having paid thousands of dollars in premiums, are left with no coverage and mounting healthcare bills. Employers are left with no coverage for themselves and their employees and are often liable for their employee's unpaid bills. Consumers and healthcare providers are left with millions of dollars in unpaid claims. Authorized and licensed health insurers are left with a fractured marketplace and are deprived premium dollars that should have flowed to the legitimate market. State governments are left with uninsured residents who are not eligible to have their claims paid

through the state guaranty fund. If they cannot pass underwriting the only option may be a state high-risk pool. State governments also incur the substantial cost of investigating and prosecuting these fraudulent schemes.

The number and scope of unauthorized health plans have spiked as health insurance premiums have begun to rise at a double-digit pace. States and the federal government have been aggressive in their response, but the problem persists.

Types of Unauthorized Plans

All the unauthorized health plans discussed in the GAO report have two factors in common. They all offer a plan that claims to provide employee benefits subject to the Employee Retirement Income Security Act of 1974 (ERISA), and they all claim to be exempt from state insurance regulation under ERISA. Unauthorized health plans take several different forms. They typically claim to be unions, business associations, professional associations, out-of-state trusts, single-employer plans, or some combination.

The operators of unauthorized health plans know that employers and individuals generally go to authorities only after they realize that their claims will not be paid. The operators exploit this delay. By the time many illegal plans are identified their infrastructure has already collapsed and claims already exceed assets. They also rely on aggressive assertions of ERISA preemption to convince licensed agents and others to market their plans without alerting regulators. When operators are challenged by the state insurance regulators or the U.S. Department of Labor they commonly resist investigations and discovery with claims of ERISA preemption. They extend delays by claiming to have troubled information systems, poor claims records and inadequate accounting procedures. When states are forced to litigate against these plans, this causes further delay (especially given the complexities of ERISA

defenses), which affords them additional time to collect premiums and dissipate assets while unfunded claims mount.

NAIC Activities

To address the problem of unauthorized health plans the NAIC has implemented a variety of initiatives.

- *Points of Contact:* The NAIC maintains a list of contacts in every state, which is posted on its Web site. This list identifies an individual in every state insurance department who is familiar with the issue of fraudulent plans and can answer questions from the public and insurance agent community. This has proven to be an important tool for accelerating the identification of suspicious plans.

- *Bulletins for Consumer and Agent Education:* The NAIC has developed bulletins for use by state insurance departments to draw attention to the issue of fraudulent plans, and provide guidance. The NAIC distributed a “Consumer Alert” designed to warn consumers about “ERISA” and “union plan” scams, to suggest some “smart shopper” questions to ask and to advise consumers to report to their state insurance department any attempts by insurance agents to sell “union” plans. The NAIC also circulated an “Agent Alert” to remind agents of their duty to inform their state insurance department any time they are approached by a suspicious entity. Any agent who sells a sham “ERISA” or “union” plan should expect to lose his or her license and to face personal liability for any claims incurred under the unlicensed coverage. Enlisting the cooperation of the agent community has been critical to the early identification of illegal plans. The National Association of Health Underwriters took the responsible

step of publishing the alert in its magazine, and forwarded many leads to state insurance regulators.

- *Direct Consumer Education:* The NAIC has budgeted \$295,000 to initiate a National Media Campaign on unauthorized insurance. This effort has just begun and will run through June 2004. This project will include media campaign development, media production, media relations and web site development. As a first step in the campaign, the NAIC printed a brochure “Make Sure Before You Insure,” which identifies signs of potential fraud and ways consumers can protect themselves.

- *Information for Licensed Insurers:* The NAIC sent to all NAIC members in June 2003 the model bulletin, “Regulatory Alert to Stop Loss Carriers and Third Party Administrators.” The regulatory alert for licensed insurance plans emphasizes the key role that licensed entities play in state efforts to combat unauthorized health entities. In addition to insurance agents, illegal entities also solicit the assistance of state licensed stop loss carriers and third party administrators to lend legitimacy to their illegal operations. The regulatory alert reminds stop loss carriers and third party administrators that, as part of their commitment to good business practices, they are obligated to review their internal controls and business practices to ensure they do not become unwitting accomplices of illegal health insurance plans. Like agents, stop loss insurers and third party administrators may risk regulatory penalties and liability for unpaid claims under state law for doing business with unauthorized entities.

- *Information for Regulators:* The NAIC writes and distributes the *ERISA Handbook* (official title: *Health and Welfare Plans under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation*.) The Handbook, which is currently being updated by the NAIC ERISA Working Group, highlights for regulators the different types of unauthorized entities that seem to be most prevalent and provides additional guidance on recognizing and shutting down fraudulent plans.

- *Information Sharing Among States and the Federal Government:* The NAIC is involved in extensive efforts to coordinate information sharing among states and the Department of Labor on a persistent basis. Information is exchanged about suspect entities, individuals, third party administrators, agents, marketing firms, stop loss carriers, reinsurers, provider groups—essentially everyone involved in every aspect of what are often complex, convoluted and extensive scams. Over the years, states have become more focused on information sharing through these efforts. Information is also shared during the four annual NAIC meetings.

- *Interstate Coordination:* The NAIC facilitates information sharing and coordination among states where a particular scam is operating. Lead state insurance departments share critical information such as: (a) a list of insureds and where they are located; (b) a list of agents marketing the plans and where they are located; and (c) names of principals involved with the plan

- *Model Law:* The NAIC Antifraud Task Force, MEWA Subgroup, is drafting a model law making it a felony to transact unauthorized insurance. This model is intended to

encourage states to increase current criminal penalties, and ease prosecution, for operation of an illegal health plan.

Conclusion

Unauthorized health plans are a growing problem that negatively impacts the entire insurance and healthcare system. The NAIC works closely with the states and the federal government to facilitate the prevention, identification and elimination of unauthorized health plans, but we must remain vigilant. The NAIC applauds this committee for holding this hearing today and beginning a Congressional dialogue which we all hope will result in greater success in this ongoing battle against illegal health plans. We offer our assistance to the committee as this discussion continues and thank you for this opportunity to participate in today's hearing.

RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

Question 1. It seems that we too often see the same faces committing these scams over and over again. How do we fix the loopholes that enable these scam artists to continue doing business?

Answer. Some of the “loopholes” have only recently been addressed, such as the U.S. Department of Labor regulation establishing standards for determining when a plan is “established or maintained pursuant to a collective bargaining agreement.” The states have noted that with this regulation, as with other efforts to clarify the law, operators have adjusted, not discontinued, their schemes. The unfortunate reality is that the complexity of ERISA, and the opportunity for great financial gain, will always attract criminal behavior. Swift and sure criminal prosecution is the most effective tool to deter these fraudulent schemes. To this end, states have become more aggressive in prosecuting cases and several states have enacted laws enhancing the penalties for the unauthorized transaction of insurance. Since these are interstate operations and clearly federal crimes, direction to federal law enforcement agencies, and additional federal law enforcement resources would greatly assist this effort.

The NAIC is currently developing a model law, which we hope will be adopted by all states, which would make the unauthorized transaction of insurance a felony and enforce greater penalties. The NAIC sees this as a key to keeping these illegal players out of the insurance market.

Question 2. From what I have seen and heard, it seems that insurance agents are on the front lines of identifying health insurance scams. Is it fair to say that agents should be forced to show more diligence in identifying and reporting these fraudulent entities? Should annual training on unauthorized entities be required as a condition of maintaining an agent's license? If you agree—what needs to happen to make those changes a reality across the United States.

Answer. All states make it clear in the law that it is illegal for an agent to assist an unauthorized plan in any way. Agents know that if they fail to exercise due diligence they do so at their professional peril. This can lead to loss of license, criminal prosecution, or, in many states, personal liability for any claims incurred under the unlicensed coverage.

Insurance agents are the crucial first line of defense in detecting unlicensed entities. To take advantage of their knowledge and expertise, the NAIC has adopted two models:

Reporting Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs (No. 220) and the Non-admitted Insurance Model Act (No. 870). Model 220 requires licensed agents, and others, to submit information to the insurance department prior to assisting in any way the transaction of insurance by certain types of multiple employer arrangements identified in the model. These reports help the departments identify unauthorized insurance arrangements before the transactions occur. The reports also help licensees identify unauthorized insurance arrangements so that they can protect themselves from potential liability for assisting in the transaction of unauthorized insurance. Model 870 confers potential criminal and civil liability on agents who assist an unauthorized insurer.

Question 3. One other note about insurance agents. Would making insurance agents liable for the medical bills of victims increase the likelihood that an agent would pick up the phone and report these scam artists?

Answer. The insurance agent who does not inform the insurance department takes an enormous risk. Model 220 makes agents who violate the notification rule personally liable in the event that an unauthorized insurer fails to pay a claim or loss. An agent is liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of the insurance contract.

Question 4. What can be done to better educate consumers as to the existence of illegal health plans?

Answer. Organized, local media campaigns, like the one being organized by the NAIC Consumer Protections (EX) Working Group, Unauthorized Insurer Media Outreach Subgroup, are effective ways to educate the general public about the scam artists that want to sign them up with non-existent insurance at “really affordable” rates. Public service announcements, television and radio spots, and billboards are all valuable ways to reach the public.

The message that consumers can call their state insurance department to learn if an entity is licensed in their state needs to be widely publicized. People need to be reminded that if it sounds too good to be true, it probably is, and any way that message can be delivered is going to help.

Question 5. What improvements can be made at the federal level to enhance communication and cooperation? Is there a way for the federal government to commu-

nicate to states what plans have true exemption under ERISA and operating in their jurisdiction?

Answer. The relationship among the states and the federal government has been increasingly cooperative. Modern technology has made it easier to share information in a timely fashion. However, both the federal government and states have concerns about maintaining the confidentiality of ongoing investigations. It is of paramount importance that information about ongoing investigation not be subject to subpoena. Not only must the legal due process rights of the accused be protected, but the success of an investigation may depend on making sure that wrongdoers do not have advance notice of investigations and disappear. Oftentimes, in the interest of safeguarding an investigation, both states and the federal government are understandably reluctant to share information that is very detailed or specific.

Communication and cooperation among the states and the federal government would be greatly enhanced by a federal privilege and a statutory structure for coordination of investigations. The privilege and structure should safeguard the confidentiality of communications among states and the federal government for the purpose of facilitating investigations into unauthorized insurance activity.

In theory, it would be helpful for the federal government to be required to inform the states about the plans that have a true exempted status under ERISA and are operating in their state. In this scenario, failure to have documentation of exempted status would allow states to act quickly to shut a plan down.

Question 6. What level of resources have states and the NAIC spent on the issue?

Answer. The issue of unauthorized insurance is a priority for the NAIC membership. The NAIC and the states have been active on a variety of fronts in addressing the issue of unauthorized insurance.

The NAIC Website has a link to a list of MEWA contacts for every state. Each contact is an insurance department regulator that is familiar with the issue of sham MEWA plans and is qualified to answer questions from the public and insurance agent community.

The NAIC has developed a number of informational bulletins for use by state insurance departments to draw attention to the issue of sham MEWA plans, and provide guidance. A consumer alert was designed to warn consumers about "ERISA" and "union plan" scams, to suggest some questions to ask and to advise consumers to report to the insurance department any attempts by insurance agents to sell "union" plans. An agent alert was developed to remind agents of their duty to inform the insurance department any time they are approached by a suspicious entity. A model bulletin titled "Regulatory Alert to Stop Loss Carriers and Third Party Administrators" was developed to remind stop loss carriers and third party administrators that, as part of their commitment to good business practices, they are obligated to review their internal controls and business practices to ensure that they do not become unwitting supporters of illegal health insurance plans. Like agents, stop loss insurers and third party administrators may risk regulatory penalties and liability for unpaid claims under state law for doing business with unauthorized entities.

The ERISA Working Group of the Health Insurance and Managed Care (B) Committee spends the majority of its time on the issue of unauthorized health plans. The working group coordinates information-sharing among states on a persistent and constant basis. Information is exchanged about suspect entities, individuals, TPAs, agents, marketing firms, stop loss carriers, reinsurers, provider groups—essentially everyone involved in every aspect of what are often complex, convoluted and extensive scams. Over the years, states have been becoming more focused on information sharing, and the NAIC has been facilitating informationsharing among the states about potential unauthorized health plans.

The ERISA Working group is finalizing updates to the "ERISA Handbook" (*Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation*), which, in large part, is devoted to creating a practical guide for state regulators to follow in preventing, investigating, identifying, and taking legal action against entities falsely claiming exemption from state laws under ERISA.

The NAIC Antifraud (D) Task Force of the Market Regulation and Consumer Affairs (D) Committee has a MEWA Subgroup that is drafting a model act making it a felony to transact unauthorized insurance. Most states criminalize unauthorized activity but few make it a felony.

The NAIC has budgeted \$295,000 for a National Media Campaign on unauthorized insurance. This effort has already begun and will run through June 2004. This project will include media campaign development, media production, media relations and web site development.

Question 7. We have heard that many of these entities cross state borders. Does that limit the effectiveness of state insurance departments in taking effective enforcement actions against these entities?

Answer. The fact that many of these scams often operate in more than one state creates an important federal government role. The problem is the federal government is unable to act as quickly as the states. The federal burden of proving breach of fiduciary duty is onerous and time consuming, especially when compared to the states' administrative process for issuing a cease and desist order.

Question 8. On average how many resources does the NAIC use to investigate companies selling health insurance on the Internet sites marketing health insurance? Has the NAIC identified any bogus health plans through Internet searches?

Answer. The NAIC, itself, is not a regulatory body and does not conduct investigations. The NAIC is a private non-profit association of the chief regulatory officials of the fifty states, the District of Columbia and the four territories. The mission of the NAIC is to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost effective manner, consistent with the wishes of its members: protect the public interest; promote competitive markets; facilitate the fair and equitable treatment of insurance consumers; promote the reliability, solvency and financial solidity of insurance institutions; and support and improve state regulation of insurance. As such, the NAIC does not investigate companies.

Each state insurance department is responsible for enforcing its own state laws, which includes the investigation of suspect entities. Suspect entities have increasingly been using the Internet to solicit customers. State insurance departments also use Internet technology to investigate suspect entities marketing on the Internet.

Question 9. What role does the NAIC play in coordinating among state investigators and Department of Labor investigators? Is this coordination sufficient, or is there a need for more formal mechanisms to ensure that federal/state and multi-state coordination that is necessary occurs?

Answer. The level of State and Department of Labor cooperation has been steadily improving over the years. State regulators participate in regional Department of Labor-sponsored conferences on the issue of sham MEWAs plans. These conferences are helpful and informative for all those attending. Department of Labor investigators participate in NAIC meetings, at least quarterly. State and federal regulators are able to meet face to face and establish personal contacts that are important in ensuring timely and effective information sharing.

RESPONSES TO QUESTIONS FROM SENATOR KERRY

Question 1. You note that unauthorized health plans discussed in the GAO Report have two factors in common: they claim to offer a plan subject to ERISA and they, therefore, claim to be exempt from state insurance regulation. Since this is now the third round of insurance scams the country has experienced, why have the states and the Department of Labor not been able to develop statutes and regulations that would address the legal gaps that allow these scams to continue? When will it be completed and how quickly do you anticipate states might adopt it?

Answer. A plan is either licensed and regulated by the state or, in limited circumstances, is exempt from state law and regulated by the federal government. The problem is that there are criminals who wish to profit from claiming that they are exempt from state law, even though they have not met the federal requirements for being exempt. These criminals exploit the complexities of ERISA by creating structures that must be investigated and adjudicated on their factual merits. They exploit both due process and consumers' need for affordable health insurance.

As long as there remains a way for any plan to be exempt from state regulation there will be criminals who will fraudulently claim that exemption to evade oversight. And, as long as a claim of federal preemption can be made, states will have difficulty shutting down known unauthorized plans. As stated in the testimony, operators of illegal health plans are very savvy. They know what claims to make and what information to hide in order to delay legal proceedings.

Question 2. Mr. Montemayor, Commissioner of the Texas Department of Insurance, in his testimony makes several suggestions for new authorities that could strengthen the ability of states to shut down insurance scams claiming exemptions. Is NAIC incorporating these and similar recommendations in the model legislation you are developing?

Answer. The NAIC ERISA Working Group, which I chair, is currently reviewing the recommendations made by Commissioner Montemayor, as well as those proposed by other commissioners and interested parties. We are hopeful these discus-

sions will yield a list of recommendations very soon that could then be shared with the Senate Finance Committee.

Mr. Chairman and Members of the Committee:

My name is Joan Piantadosi. As a victim of the health insurance scam created and operated by Employers Mutual, I appreciate the opportunity to take part in this hearing. In 2001, I was paying insurance premiums on behalf of my family and employees to Employers Mutual believing that it was a legitimate health insurer. During that time my husband experienced a medical trauma resulting in the need for a liver transplant. During this time, the medical trauma was exacerbated by emotional turmoil when we discovered that Employers Mutual was not a legitimate insurer. Due to the company's failure to pay our medical claims, there are more than \$500,000 in unpaid bills for my husband's medical care.

Our story began in July 2001, when insurance agents contacted me regarding a health insurance plan being offered by Employers Mutual. According to one of the agents, I could save 30% on my health insurance. The agent told me that the insurance was offered through several associations composed of thousands of individuals whose group association entitled them to very low rates.

Upon learning of an impending rate increase by Humana and that Employers Mutual premiums would be significantly lower, I decided to switch coverage from Humana to Employers Mutual on behalf of my family and two employees in our family business. On August 1, 2001, I began paying premiums.

In November 2001, my husband began experiencing severe neck and shoulder pain. Our doctor referred us to an orthopedic surgeon who administered an epidural in an attempt to provide some relief. Employers Mutual pre-approved the epidural as well as the office visits to our doctor and to the orthopedic surgeon.

When the epidural failed to alleviate my husband's neck and shoulder pain, he began taking over-the-counter pain relievers. Unbeknown to us, the painkillers aggravated his pre-existing liver condition. We would learn afterwards that, over the course of a few weeks, my husband's already poorly functioning liver would shut down completely.

Before the liver problems became apparent, the orthopedic surgeon thought my husband would benefit from another epidural for his neck and shoulder pain. For several weeks, I tried in vain to reach someone at Employers Mutual to obtain pre-approval for the procedure. When I finally spoke with an Employers Mutual representative on December 19, 2001, I was referred to a court-appointed fiduciary. To my alarm, I was advised that the company was shutting down and would not pay any claims submitted after December 31, 2001. Armed with a letter from the court-appointed fiduciary, we were able to get a second epidural on December 21, 2001.

On Christmas Eve, my husband slipped into a coma due to complications from his failing liver. On Christmas day, he underwent a 12-hour surgery at a Fort Lauderdale hospital. On New Years Eve, after six days of being comatose, my husband regained consciousness. The doctors informed us that he needed to be evaluated to determine whether a liver transplant would be possible. The evaluation had to be conducted in Miami at Jackson Memorial Hospital; however,

the hospital would not admit him until Employers Mutual pre-approved payment of the medical bills.

Again, I had to find a way to hold Employers Mutual accountable. First, I personally attempted to obtain pre-approval for the transplant evaluation from the court-appointed fiduciary. When those efforts were unsuccessful, I had my attorney telephone the fiduciary on behalf of my husband and me. Understandably, we were desperate.

On January 11, 2002, the court-appointed fiduciary sent a pre-approval for the transplant evaluation. However, the pre-approval did not guarantee payment. My husband was admitted to the hospital on January 12, 2002. He stayed there for two weeks while the evaluation was conducted. After being told that he would be placed on the transplant recipient list, he was sent home.

In early February 2002, we were informed that since we lacked insurance coverage, we would have to pay a deposit of \$150,000 before my husband could enter the hospital's Liver Transplant Inpatient program. We simply did not have \$150,000 to cover the deposit. Consequently, my husband was removed from the recipient list.

Like the preceding months, the next two weeks were an emotionally tumultuous time for us. We feared, among other things, that my husband might die while we were attempting to deal with the predicament of being uninsured despite having paid premiums to what appeared to be a legitimate health insurer.

Fortunately, our story ends on a positive note. First, Ilene Lieberman, a Broward County Commissioner, intervened on our behalf and my husband was placed back onto the transplant recipient list. Second, we were able to obtain new insurance in February 2002, which took effect shortly afterwards on March 1st. Third, and most importantly, my husband underwent a successful liver transplant on April 10, 2002. Thankfully, the new insurance company covered the surgery.

Again, thank you for giving us the opportunity to share our experience with you concerning this health insurance fraud. I would be happy to answer any questions you might have. Our medical bills during this time period exceeded \$800,000. Bills of about \$500,000 were incurred during the time that Employers Mutual should have provided coverage and remain unpaid. Although our new insurance company covered \$300,000 of our medical bills, we are saddled with personal debt that totals \$33,000 for medical expenses incurred while we were without any type of health insurance from January 2002 to March 2000.

**Opening Statement
Senator John D. Rockefeller IV
March 3, 2004**

Mr. Chairman, thank you for holding this hearing today. It's a great opportunity for us to discuss ways to prevent health care fraud and abuse.

Small business owners face substantial barriers to providing health insurance coverage for themselves and for their employees. They are often the hardest hit by rising health care costs, and the ongoing economic downturn has forced many small employers to increase employee cost-sharing, cut benefits or discontinue coverage altogether. As more companies pass the costs of health insurance on to their employees, more American workers are joining the ranks of the uninsured because they cannot afford the higher premiums, deductibles, and co-pays.

In order to help small businesses and their employees access affordable, high-quality health insurance, we should seek to build upon models of dependable insurance coverage that offer tough consumer protections and adequate regulatory standards.

Current proposals to exempt Multiple Employer Welfare Arrangements – or MEWAs – from state insurance law and regulatory oversight are a step in the wrong direction. All 50 states have an extensive body of law establishing the rules for those who sell insurance products. Those rules include benefit mandates, consumer protections, financial solvency standards, fair market practices, grievance and appeal procedures, non-discrimination requirements, and ratings rules. Legislation to preempt state insurance regulation and oversight would turn back the clock on the progress states have made over the last twenty years in protecting consumers from fraudulent MEWAs and unauthorized health plans.

In my home state of West Virginia, we have seen first-hand what a lack of state regulation means to consumers who buy an insolvent insurance product. In 1997, Corbin Ltd., a textiles production company in Huntington, West Virginia, created a self-funded health-insurance plan. Seamstresses gave up two years of raises so that Corbin could fund this plan and they could have access to health insurance. Yet, in 2001, Corbin shut down the self-funded plan without notifying its employees. Company employees – many of whom had worked for Corbin Ltd. for decades – found out their medical bills weren't being paid when they got collection notices in the mail. By the time the company filed for bankruptcy in 2003, 444 former employees were left to pay over \$2 million in medical bills that the company should have paid.

Employees of Corbin Ltd. turned to the West Virginia Insurance Commission for help, but under ERISA states are barred from regulating self-funded single-employer plans. Instead, the Department of Labor regulates these plans. But the Department of Labor does not require self-funded plans to meet licensing requirements or strict solvency standards. And there are no federal regulations that address the problem experienced by Corbin employees – when an employer refuses to pay legitimate health-care bills that it is responsible for paying.

The Corbin example highlights key problems with our limited federal regulatory framework – there is a lack of standards and the Department of Labor does not have the oversight capacity to protect consumers. Instead of worsening the problem of insurance fraud and abuse by putting plans under the sole regulatory authority of the federal government, we should seek to further clarify state authority to regulate insurance and close the existing loopholes under ERISA.

I thank the Chair.

**Statement of Senator Olympia J. Snowe
United States Senate Committee on Finance Hearing:
HEALTH INSURANCE CHALLENGES: "BUYER BEWARE"
March 3, 2004**

Mr. Chairman, thank you for convening this hearing on a subject we all wish were not so pressing. When I became Chair of the Small Business Committee, I began to learn more about the difficulties that small businesses are having finding affordable health insurance. Small businesses are desperate and willing to take any offer that they can afford, rather than stay with companies that they recognize but that may be too expensive and would put too much of a strain on their companies.

Unfortunately, this desperation makes these hard working, well meaning employers, and their employees, vulnerable to insurance scams and frauds that are lurking out there waiting to prey upon those who feel they have no other options. For this reason, I joined the request to GAO, initiated by the previous Chair of the Small Business Committee, Senator Bond, to investigate these bogus insurance plans and their impact on small businesses.

What we will hear today from GAO and the other witnesses is truly upsetting. The notion that these plans were taking people's money with no intention of providing the necessary health insurance coverage for the life saving treatments and procedures that enrollees expect is galling. The accounts from Ms. Almond and Ms. Piantadosi of how they found out at the absolute worst moments that their health insurance was a fraud are chilling.

The extent of these scams is also astounding. GAO's discovery that 144 plans were operating between 2000 and 2002, selling coverage to 15,000 employers and more than 200,000 individuals, resulting in at least \$252 million in unpaid medical claims is clearly not the full scope of this problem. And sadly, no part of the country was untouched by these scams. My own State of Maine was found to have between 15 and 24 unauthorized entities operating during the period covered by GAO's report.

Operators of these plans are masters at playing an intricate insurance "shell game." They know how to stay one step ahead of the enforcement authorities by characterizing their operations as just beyond the reach of that authority. If a state pursues them, they will claim that they are federally regulated. If the federal government comes after them, they will say that they are a state regulated insurance company. They exploit our legal system to delay the process so that premiums keep coming in with the payments never going out.

Today we will also hear about the efforts to stop these schemes. While

these plans have benefitted from confusion between state and federal efforts, there is now a much more coordinated approach which will hopefully yield more effective and efficient enforcement so that fewer people get burned by these scams. The ultimate cure for these frauds is to shine the light of day into the dark corners where they thrive. Educating the consumer can turn potential victims into advocates and make all the difference in helping to identify fraudulent plans and bring them to justice.

We must also provide consumers with information so they can quickly verify the legitimacy of the firms from which they purchase insurance and give them a clear indication when they *are* purchasing insurance as opposed to some sort of a discount plan. It's too late to find out in the emergency room that they have *not* purchased the necessary coverage for their needs.

Mr. Chairman, this hearing today should be the start of our efforts to close the loopholes and gaps that allow these frauds to take advantage of people when they are the most vulnerable. I look forward to working on this issue so that small businesses and their employees can be sure that the health insurance on which they depend will be there when they need it most. Thank you for holding this hearing and I look forward to hearing from the witnesses.

COMMUNICATIONS



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COMMENT

Howard Goldblatt, Director of Government Affairs

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Dennis Ray
Executive Director

A national coalition of consumers,
government agencies and insurers
dedicated to combating all forms of
insurance fraud through public
information and advocacy.

The Senate's inquiry is a welcome step that will help focus more national scrutiny of a massive insurance swindle that endangers the lives and health of working Americans in every state, and undermines small businesses that are already reeling from a troubled economy.

Phony health plans are one of the largest and most vicious insurance swindles of the last 10 years. They've operated in virtually every state, and victimized hundreds of thousands of working Americans and their families.

The swindles prey on the desperation of many small businesses to find affordable health coverage during a shaky economy combined with double-digit increases in health coverage annually.

The scam operators have easily sold bogus health coverage at low prices with generous benefits and suspiciously easy sign-up — even for people with pre-existing conditions that might disqualify them from other health plans.

Regulators were caught off guard by the sheer size of the swindles, and the speed with which they spread around the U.S. Most regulators barely realized the fake health plans were operating in their own backyards until complaints by defrauded policyholders started piling up on their desks.

But since they began uncovering the scams, regulators have moved fast to shut them down. Many of the largest plans — the low-hanging fruit — are out of business. But nobody knows for sure how many illegal health plans are still operating under the radar.

Regulators still have a long way to go before shutting down this national scandal for good. Among the needed steps:

Stronger state laws. State legislators should consider making it a crime for insurance agents to sell unauthorized insurance. Florida has passed such a law.

Better coordination. State and federal regulators can uncover scams and gather evidence far more efficiently by coordinating investigation. They should work jointly wherever possible and share information continuously.

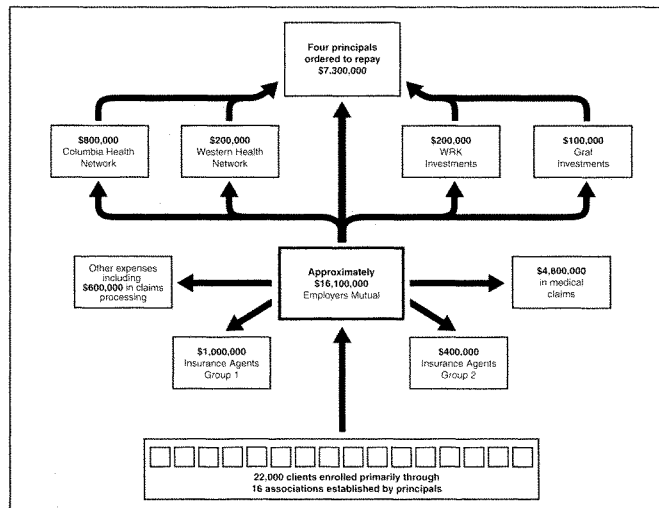
More public education. National outreach campaigns can be weapons of mass instruction. The scams succeed because businesses don't know the warning signs. Regulators, insurance groups and others must commit to an ongoing, continuous and well-funded national outreach campaign to educate businesses about the scams.

-more-

Page 2 of 2 (Coalition comment)

Aggressive criminal prosecution. More-aggressive criminal prosecution leading to serious jail time is the best way to shut down crooked operators for the longterm. Too many states rely mainly on cease-and-desist orders to stop swindles. While helpful, these are mainly Band-Aid solutions that leave the operators still on the streets. Jail terms will shut down dishonest operators here and now, and deter others for the future.

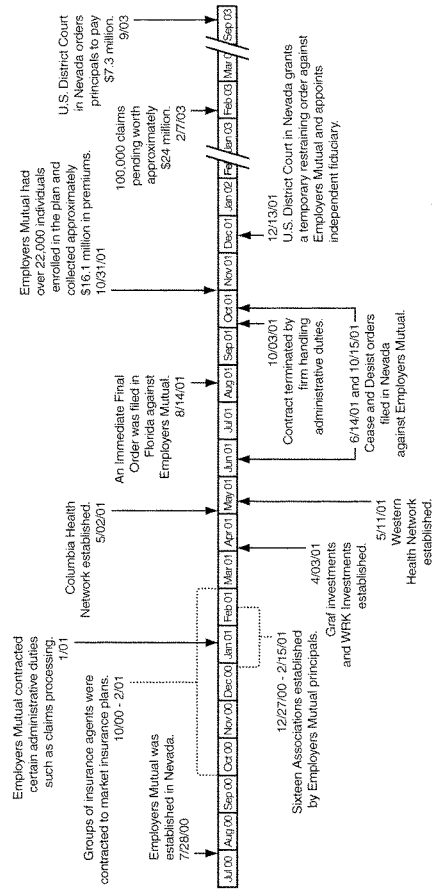
Proceeds of Employers Mutual Insurance Scam



The independent fiduciary and DOL reported that they were prevented from fully accounting for the money collected and paid out by Employers Mutual, its principals, and contracted companies due to the scope of its operations and the disarray and incompleteness of the records they were able to recover. Therefore **all dollar figures are approximate.**



Timeline of Employers Mutual Insurance Scam



Source: DOL, court documents and the independent fiduciary.



March 3, 2004

The Honorable Charles Grassley
Chairman, Committee on Finance
SD-219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Grassley:

On behalf of the 600,000 members of the National Federation of Independent Business (NFIB), I appreciate the Committee's attention to solving the problems of insurance fraud. Small business owners need to be aware of fraudulent health insurance schemes. Small business organizations like NFIB can be helpful in publicizing the dangers of these fraudulent plans, and we look forward to working with you in this effort.

Today small businesses are struggling to afford double-digit increases in health insurance premiums and often shop from year to year for new, cheaper insurance policies. We are concerned that in hard times like these employers look to any option of providing health care to their employees, and some options may be too good to be true. In the past we have alerted our members to potential fraud and abuse and encouraged them to be careful in their purchasing decisions.

We welcome any recommendations that could come out of today's hearing. If the committee provides any educational materials we would be happy to provide those to our members. Thank you for your attention to this matter and we look forward to working with you in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "Dan Danner". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Dan Danner
Senior Vice President
Public Policy