
Association Health Plans:

Loss of State Oversight Means Regulatory Vacuum and More Fraud

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Executive Summary

This report analyzes the impact of legislation introduced in the U.S. Congress (H.R. 525/S. 406) that would federalize the regulation of health insurance arrangements called association health plans (AHPs). It concludes that by exempting AHPs from state oversight, the legislation would create a regulatory vacuum and allow scam operators to use new federal AHP preemption provisions as a shield to avoid regulation and oversight. As a result, the passage of this legislation would have the unintended consequence of widespread fraud threatening the coverage and financial security of millions of Americans.

There has been a 30-year history of health insurance scams involving associations and multiple employer arrangements. Scams flourished after Congress exempted these arrangements from state oversight in 1974 through the Employee Retirement Income Security Act (ERISA). Operators targeted small businesses and self-employed people through legitimate and phony associations. They collected premiums for non-existent health insurance, did not pay medical claims, and left businesses, workers and providers with millions of dollars in unpaid bills and patients without health insurance coverage. The U.S. Department of Labor, having the responsibility for oversight, was not able to protect businesses and their workers.

In response to widespread fraud, in 1982 Congress amended ERISA to restore states' authority and to allow both the states and the federal government to regulate in order to better protect consumers covered by associations and multiple employer arrangements. Despite Congressional interventions, phony insurance sold through associations remains a problem. During a recent cycle of scams, 144 operations left over 200,000 policyholders (number of people is unknown) with over \$252 million in medical bills. However, it is likely that there would have been even more victims if states' authority was restricted, as the bills seek to do. Between 2000 and 2002, state investigators shut down 41 illegal operations selling coverage through phony and real associations, while the Department of Labor shut down 3 operations.

This report concludes that AHP legislation would exacerbate the problem of health insurance fraud perpetrated against small businesses and their workers in several ways.

Preempting state oversight and thereby prohibiting states from protecting consumers

States currently have the authority and resources to prevent, identify, and shut down fraudulent plans and protect consumers. States prevent fraud by using comprehensive early warning systems — including using insurance agents as their “eyes and ears.” States have also enacted laws that require agents to report fraud and impose financial penalties on agents that sell phony coverage. Moreover, states can move quickly to shutdown fraudulent plans by issuing cease and desist orders without going to court; they also protect consumers by seizing plan assets. Different from states, federal regulators must ask a federal court to close an unauthorized plan — investigations and actions that take several years with little hope of recovering assets and more consumers defrauded while the phony entity stays in business.

The existing tools that states use to prevent fraud cannot be replicated at the federal level and would be lost under AHP legislation. The history of scams involving associations demonstrates that when the federal government has had sole oversight authority, fraud flourished with unscrupulous individuals leaving businesses and their workers without health coverage and with millions of dollars in unpaid medical bills.

Creating regulatory loopholes likely to foster fraud

Unlike state regulation of insurance, the bills would establish a regulatory structure that relies on self-reporting and self-regulation, constrains regulators' authority to verify information, and limits authority to intervene after problems occur by requiring the federal government to go to court to shut down an AHP.

There is no specific provision in the bill that would prohibit scam operators, even those that have been convicted of a felony or those who have been shut down in the past for operating phony arrangements, from controlling, owning or managing an AHP. Furthermore, the required class certification for fully insured AHPs, upon the filing of paperwork and payment of a fee, without any verification or investigation would make it easy for unscrupulous individuals to obtain federal certification by submitting false documentation. Such certification would be akin to a seal of good housekeeping that operators could use to attract unsuspecting businesses. Once certified, both federal regulators and the courts would have difficulty shutting down a certified AHP because the bills would restrict the Department of Labor and the courts' authority over insured associations. Limited judicial or administrative authority to order an AHP to shut down, coupled with a prohibition on states from doing so, means a significant gap in oversight that would leave businesses unprotected.

The legislation also contains broad preemption provisions that would prevent states from regulating both licensed and unlicensed entities that offer coverage to federally certified AHPs. State regulators would be prohibited from shutting down unlicensed entities that sell coverage through federally certified AHPs.

The bills' regulatory framework, broad preemption of states, deficiencies in federal regulatory tools, and resource constraints — that have already proven to hinder the Department of Labor's ability to enforce its current responsibilities — create conditions that would make it almost impossible for the federal government to protect businesses and workers covered by AHPs against fraud. The proposed regulatory structure is precisely the framework that in the past resulted in widespread fraud and prompted Congress to clarify that states could regulate these arrangements.

Expanding the preemption shield: creating new legal questions, broadly preempting state authority and creating confusion about regulatory oversight

The legislation would create a new opportunity for promoters of scams to use new preemption provisions as a shield to avoid state oversight by claiming preemption. New legal questions about the scope of preemption would provide new reasons for promoters to challenge state authority in court. Consistent with past behavior, unscrupulous operators will invoke preemption arguments in every case where a state attempts to regulate the arrangement, even one that is not preempted. When forced to litigate, states require tremendous resources and time. While litigating, promoters continue to collect premiums from unsuspecting consumers, embezzle and hide assets, and leave businesses and their workers responsible for millions of dollars in medical bills.

Broad preemption in the bills would also create confusion over oversight. Should the bills be enacted, there would be at least nine types of entities in the marketplace: federal AHPs, AHPs that qualify for certification but choose not to become certified, AHPs that lose federal certification, AHPs that do not qualify for federal certification, AHPs falsely claiming to be federally certified, federal AHPs that should not have been certified because they are phony, multiple employer arrangements that are not federally certified as AHPs, state licensed insurance companies that do business with federal AHPs, and phony insurance companies selling to federally certified AHPs. A lack of clear standards for which regulator has authority to regulate would mean loopholes and no regulation of certain arrangements.

In addition to questions about state authority vis a vis federal, by creating two different licensing schemes for federal certification — self-insured and fully insured AHPs — the legislation would create further confusion and opportunities for unscrupulous individuals. While the federal government would be responsible for self-insured AHPs, fully insured ones would be subject to federal authority and limited authority of one state, chosen by the AHP. State authority ends at its borders. Having one state in charge of overseeing coverage sold in 50 other states is a recipe for no oversight. This structure would create 51 different regulators and sets of rules that scam operators could exploit to avoid regulation. The bills' broad preemption provisions would restrict state regulators' authority and a state would be preempted from shutting down an illegal company doing business with a federally certified AHP. This would have adverse consequences for businesses and their workers.

As America's small business owners struggle to find affordable health insurance for themselves and their workers and in light of an influx of health insurance scams that prey on small businesses, legislative actions should seek to improve protection for small businesses and their workers.

Businesses and workers expect their covered claims to be paid when they have bought insurance. They expect that when an insurer is insolvent, that they will be protected. They expect that government is watching out for them and is acting to prevent fraud and mismanagement by insurance entities.

Unfortunately, the regulatory approach contemplated in the AHP legislation would leave many businesses and workers at the mercy of scam operators. The consequences are predictable: bankruptcy, delayed or foregone medical care, and loss of coverage for America's businesses and workers.

INTRODUCTION

*"...what is shocking is that the insurance cheats are using the Federal ERISA law and the principle of Federal preemption as an offensive weapon, in court and out, against consumers. In this way, they have largely avoided regulation, repayment, or prosecution. In my opinion, the insurance trust swindle has the potential to become the most sophisticated and profitable white-collar crime in America.... It is high profit and very low risk crime under the existing laws ... an operator with virtually no capital can go into the ERISA trust benefit business and become a very rich person by cheating people out of their premiums and face almost no chance of going to jail."*¹

Attorney General, State of Illinois (a former
Assistant U.S. Attorney) 1982 testimony before Congress

*"For almost 18 years now, conmen, crooks, and hucksters have been able to take advantage of a continuing regulatory vacuum (be it actual or perceived) in the area of self-insured employer sponsored health benefit programs to fleece unsuspecting employers and their employees of hard-earned premium dollars. They have built their lavish lifestyles on the shattered lives of innocent men, women and children while regulators have argued with one another over who has jurisdiction and whether the problem already has been solved."*²

U.S. Senate Permanent Subcommittee on Investigations, March 1992

*"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."*³

Senator Grassley, Senate Finance Committee,
Investigation on Health Insurance Scams, March 2004

Since the enactment of a federal law called the Employee Retirement Income Security Act of 1974 (ERISA), which replaced state oversight of employee benefits with federal, there has been a history of scams connected to ERISA. Promoters of phony insurance have used this federal law as a way to avoid scrutiny by state investigators and law enforcement. This, coupled with unsuccessful oversight at the federal level (partly due to resource constraints and limitations on regulatory authority), has contributed to ERISA scams.

Thirty years after ERISA's enactment, health insurance coverage scams continue. In the current cycle of scams, operators target small businesses and self-employed people through association health plans (legitimate associations and phony associations they set up), collect premiums for non-existent health insurance, and leave patients with millions of dollars in unpaid medical bills and without health insurance. Between 2000 and 2002, 144 such operations left over 200,000 policyholders with over \$252 million in medical bills and without health insurance.⁴ Four of the largest left 85,000 people with over \$100 million in medical bills.⁵ Consequently, some victims were forced into bankruptcy. Others have lifelong physical conditions as a result of delayed or foregone medical care.⁶

In the context of a 30-year history of health insurance scams and Congressional efforts to address the problem, this report analyzes one federal proposal, H.R. 525/S.406, that seeks to federalize the regulation of association health plans. The report concludes that the proposed legislation if enacted is likely to exacerbate the current problem of health insurance fraud and to leave small businesses and their workers unprotected.⁷

BACKGROUND

What are association health plans?

Millions of working Americans rely on associations for their health insurance coverage.⁸ Associations vary in size, membership, and goals. Professional and trade associations, such as state medical associations, generally limit membership to a specific trade or business. Other professional associations, e.g., a local chamber of commerce, while promoting common business interests of their members, have a broad membership of trades and professions. There are associations for people with common personal interests, e.g., travel, hobbies, etc. Finally, there are also “captive” associations that are merely marketing schemes for insurers. Captive associations can be owned by or controlled by insurers and their decisions are made to promote the financial interests of the insurers.⁹

Associations may provide health insurance as a benefit of membership. Those that offer health insurance may do so as a primary benefit of being a member of the association, while for others, offering health coverage is secondary to providing other services and benefits to members, such as professional credentialing or advocating on behalf of members.

Although many have helped employers finance health benefits for employees, some such arrangements have also presented opportunities for unscrupulous individuals to defraud employers and their workers. Either by selling coverage to legitimate associations or by establishing phony ones, promoters have used associations as a vehicle to defraud businesses and their workers.¹⁰

In the recent cycle of health fraud, real and phony AHPs have been used as a principal way to promote phony insurance.

AHPs and MEWAs

Generally under ERISA, an association health plan (AHP) is a type of a multiple employer welfare arrangement (MEWA). ERISA defines a MEWA as any arrangement through which two or more employers and self-employed individuals obtain health insurance coverage. This paper focuses on AHPs because in the recent cycle of health fraud, real and phony AHPs have been used as a principal way to promote phony insurance.¹¹

Health insurance scams promoted through AHPs

Promoters of phony health insurance target small business owners and self-employed people through associations for economic and legal reasons. As a way to attract a large volume of business quickly, they sell through well-established trade and professional associations. They also establish their own associations, taking advantage of a positive experience that some consumers have had with associations, collecting membership fees for a phony association and premiums for phony coverage.

Health Insurance Scams Promoted through Phony and Real Association Health Plans

Employers Mutual LLC left over 30,000 people nationwide without health insurance and with over \$27 million in medical claims. The amount in medical bills may be higher; \$54 million in claims have been filed but only \$27 million have been verified. In 2004, several operators of Employers Mutual LLC were indicted by a federal grand jury.¹² Employers Mutual LLC sold its coverage:

- ◆ through existing associations including the National Writers Union, a professional association for journalists established in 1983;
- ◆ through sixteen associations they established — American Association of Agriculture; Association of Automotive Dealers and Mechanics; Association of Barristers and Legal Aids; Communication Trade Workers Association; Construction Trade Workers Association; American Coalition of Consumers; Association of Cosmetologists; Culinary and Food Services Workers Association; Association of Educators; Association of Health Care Workers; National Alliance of Hospitality and Innkeepers; Association of Manufacturers and Wholesalers; Association of Real Estate Agents; Association of Retail Sellers; National Association of Transportation Workers; and National Association of Independent Truckers.¹³

American Benefit Plans (ABP) left over 40,000 people nationwide without health insurance and with over \$28 million in unpaid medical bills.¹⁴ ABP sold coverage through:

- ◆ four associations they created — the National Association for Working Americans, the National Association of Working Americans, the United Employer Voluntary Employee Beneficiary Association, and the United Employee Voluntary Employee Beneficiary Association (emphasis added).¹⁵

Promoters induce well-established associations and people to enroll by offering lower premiums than available through licensed companies. They explain lower premiums using perceived and in some cases existing legal ambiguities. Promoters falsely claim to be “ERISA plans” exempt from state insurance laws. They claim that low premiums are a reflection of the ERISA exemption (self-insured ERISA plans are exempt from state insurance laws). These false claims enable promoters to collect premiums, to not pay claims, and to leave hundreds of thousands of victims with millions of dollars in outstanding medical bills. They use collected assets to buy real estate, expensive cars, and other personal items. Some hide assets in off-shore accounts.

Small businesses and self-employed people stuck with medical bills

Small businesses and their workers defrauded by AHPs have few legal options. In some cases court appointed receivers find some assets. In other cases, courts order restitution to be paid to the victims.¹⁶ Typically, however, there are not enough assets to pay fully all outstanding medical bills. According to the GAO, only \$9.6 million in assets were recovered, but over \$123.6 million was owed for medical bills between 1988 and 1991.¹⁷ 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 medical care will be paid for by the plan, victims are left responsible for their medical bills.

Some victims lose their life’s savings and their homes. With collection agencies aggressively pursuing victims to pay outstanding medical bills, some end up with bad credit or are forced into bankruptcy.¹⁸ Some victims are left with lifelong medical conditions.

Victims of Recent Scams

Marie Almond, a small business owner bought health insurance from Employers Mutual LLC. After \$65,000 in bills for chemotherapy and other breast cancer treatment, Marie learned that the company she believed was a real insurance company was shut down for “operating a sham business” by several states. Subsequently, she learned that she needed another operation. In her own words, “My doctor strongly recommended that I receive treatment at a 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 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.”¹⁹ Marie owes \$71,000 in medical bills that should have been paid by Employers Mutual LLC.

Joan Piantadosi, a small business owner bought health insurance from Employers Mutual LLC through an association for her self, her family, and her employees. She was left with more than \$500,000 in unpaid medical bills for her husband's treatment during the time she was covered by Employers Mutual LLC. On top of that, her husband needed a liver transplant to live. In her own words, "[W]e 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."²⁰

Judy Coburn thought that she had insurance through the National Writers Union (NWU), a professional association for journalists. NWU contracted with Employers Mutual to sell coverage to its members. Judy only lost \$12,000 (some in premiums, the rest she borrowed to have eye surgery). Unfortunately, Judy now has permanently impaired vision in one eye because she could not get her surgery in time to save her vision. So unlike other victims, she is lucky that she does not owe hundreds of thousands of dollars to her physicians. Unlike other victims, however, she will never recover her vision.²¹

The Huffstutlers bought health insurance through a professional association. Lisa Huffstutler was nine months pregnant when she and her husband figured out that their health insurance was phony. She feared that her doctor would find out and would refuse to deliver her baby. In addition to worrying about giving birth to a healthy baby, Lisa agonized over whether she would be admitted to a hospital and whether she would have a doctor at her side for the delivery. Lisa's family accumulated thousands of dollars in medical bills. Although the illegal company was shut down by state regulators, it had few assets and Lisa's bills were not paid. Several doctors agreed to put the Huffstutlers on a payment plan and reduced some of the bills. However, thousands of dollars owed to the hospital and other providers forced the Huffstutlers to declare bankruptcy.²²

There are thousands of victims like Marie, Joan, Judy, and the Huffstutlers.

REGULATION

Both the federal government and the states have authority to regulate AHPs, although this was not always the case. Each have different and complementary tools, resources, and strategies.

History of regulation

When Congress federalized regulation of employee benefits by enacting ERISA, it severely restricted state authority to regulate multiple employer arrangements. Under the 1974 statute, states could not regulate arrangements that were considered to be an “employee welfare benefit plan” also called “an ERISA plan.”²³ The U.S. Department of Labor became responsible for regulating these.²⁴ To determine if an arrangement was an ERISA plan, a state (and in many cases a court) had to apply a very technical and complex federal standard requiring a fact intensive inquiry.

Ambiguity about ERISA’s preemption and lack of oversight by the U.S. Department of Labor resulted in proliferation of scams. Although there is no data documenting how many people were affected nationwide, according to California’s regulators, between 1977 and 1982, there were 45 multiple employer arrangements in the state that stopped operating. Eighteen of those became bankrupt, two of which left over \$7 million in unpaid medical bills and thousands of workers without health insurance.²⁵ In several of these, the state was successful in getting criminal convictions.²⁶

After ERISA’s passage, the U.S. Department of Labor claimed not to have authority over arrangements that were not “ERISA plans.”²⁷ Most multiple employer arrangements, also called multiple employer trusts (METs), were not ERISA plans.²⁸ However, when states tried to regulate such arrangements, operators successfully claimed ERISA exemption from state law.²⁹ In testimony before Congress, California’s deputy commissioner described their experience in attempting to shut down illegal multiple employer arrangements:

*“We have run into some incredible delaying tactics which have allowed questionable METs to operate. In every instance that the MET did not voluntarily close its door, the issue of Federal preemption was raised. After several years of litigation, we would ultimately prevail, but not before new trusts were formed out of the old ones, forcing us to commence this lengthy judicial process once again.”*³⁰

Some unsuccessful legal challenges, cases requiring significant resources to litigate and expensive factual investigations about ERISA plan status, had a dampening effect on states’ ability to regulate non-ERISA plans. More importantly, while states had to defend their authority in court, scams continued to operate, collecting premiums from consumers and ultimately leaving thousands of victims with millions of dollars in medical bills.

The U.S. Congress, recognizing that the federal government could not adequately protect consumers against fraud and insolvency of multiple employer arrangements, sought to remove preemption ambiguities in ERISA. Trying to make state oversight less difficult, in 1982 (effective in 1983) Congress

The U.S. Congress, recognizing that the federal government could not adequately protect consumers against fraud and insolvency of multiple employer arrangements, sought to remove preemption ambiguities in ERISA.

amended ERISA to limit its preemptive effect on state law. This law is also known as “the Erlenborn amendment” named after the former Congressman who led the effort to address fraud and insolvency of multiple employer arrangements. Congressman Erlenborn (R – IL) held field hearings in 1982 to examine how multiple employer arrangements escaped from state and federal oversight. Consequently, Erlenborn introduced the “Multiple Employer Welfare Arrangements Act of 1982” (H.R. 6462), which Congress passed to clarify states’ oversight authority.³¹

As a result of these amendments, states can regulate multiple employer arrangements. With almost no limitations, ERISA allows states to regulate MEWAs — defined broadly to include all types of arrangements offering health coverage to two or more employers or self-employed individuals. Excluded from the definition are collectively bargained union plans, rural electric and rural telephone cooperatives.³²

Currently, most consumer protections for people covered by multiple employer arrangements, including association health plans, are state-based. State requirements include licensing, solvency standards, coverage benefit requirements, external appeal laws, and other standards for both MEWAs and the products they offer. Federal standards are generally limited to fiduciary obligations, disclosure and notice requirements, and more recently a requirement to register with the U.S. Department of Labor.³³ ERISA does not require MEWAs to be licensed and there are no federal solvency, external review, or other consumer protections similar to those found in state insurance law.

States and the federal government: regulatory authority and enforcement strategies

As a result of the Erlenborn amendment to ERISA, state insurance departments and the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA, formerly PWBA) have authority to regulate MEWAs. Generally, states have broader administrative authority than the federal government to address fraud problems. Also, each have developed different enforcement strategies. A lack of effective regulatory tools and resource constraints, in part, is why the U.S. Department of Labor has not been able to effectively oversee association health plans and other MEWAs under its current jurisdiction.

Because some MEWA cases involve criminal activity — embezzlement, wire and mail fraud — and because civil actions are merely the cost of doing business (for many operators, especially the ones who are repeat offenders), various federal government agencies and state-based law enforcement are also involved in investigating and prosecuting these cases.

Early Detection Strategies

To try to detect illegal activities quickly, states have developed enforcement strategies such as using licensed insurance agents as “eyes and ears” as well as holding agents financially responsible for unpaid bills if they sell illegal coverage. For example, in Louisiana as a result of a tip from an agent, insurance department staff attended a marketing meeting for an unauthorized health plan. The evidence from this meeting enabled the department to close the plan within eighteen days of the marketing meeting.

At the federal level, reporting “unlicensed” arrangements is not an option 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. This makes it almost impossible for federal regulators to find illegal operations before they spread nationally and leave thousands of victims.

Many states have also implemented successful strategies to identify suspicious behavior through consumer complaints and inquiries; this includes automatic referrals for investigation. Different from states, federal regulators generally initiate investigations when there is a pattern of complaints. By the time a pattern emerges, an illegal arrangement could already be operating nationally — in 10 months Employers Mutual LLC spread nationwide and collected \$14 million in premiums. By then, it is too late to help consumers covered by the illegal arrangements because assets disappear quickly.

State Enforcement Tools to Shut Down a Phony Insurer and Seize Assets: Administrative Cease and Desist Authority and Receiverships

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. Through an administrative procedure, a state insurance commissioner can shut down an illegal arrangement by finding that it is operating without an insurance license. For an administrative procedure one does not have to wait to get on a court’s trial calendar, evidence not admissible in court may be allowed in an administrative hearing, and delay tactics available in a court procedure (e.g., a motion to dismiss a case) are generally not available in an administrative proceeding. State administrative C & D Orders can help stop the spread of an illegal plan within a state. One problem is that operators of scams move to other states or change names and continue operating. However, even temporary closures of illegal operations have helped to slow down the spread of scams and more importantly have helped regulators to seize unspent assets to pay outstanding claims.

States also have receivership authority, which is often the only way to find assets to pay claims of victims.³⁴ State receivership laws allow insurance departments to take over financially failing companies, to find and seize assets, and to preserve assets for the benefit of insured people. This authority is important to stop mismanagement of assets or outright embezzlement of premiums. Because assets disappear quickly in Ponzi schemes, the ability to take over an arrangement expeditiously is important.

Additionally, for victims receiverships are important because when there are not enough assets to pay all claims, receivers may negotiate with providers for a reduced payment in exchange for providers agreeing not to seek full payment from victims. In one of the most successful receiverships — American Benefits Plans, which is an ongoing state receivership — the receiver has been able to pay \$12.4 million of the \$28.4 million in outstanding medical bills.³⁵ During the last cycle of scams between 1988 and 1991, victims were left with over \$123 million in unpaid medical bills. Less than \$11 million in assets was recovered.

Federal Enforcement Tools to Shut Down a Phony Insurer and Seize Assets: Federal Court Only

During the current cycle of scams, state insurance departments using their broad administrative authority and oversight strategies have shut down 41 illegal operations compared to the federal government's three.

The U.S. Department of Labor does not have cease and desist authority or similar administrative authority to shut down an insurance scam, but must file and win a lawsuit in federal court.

Federal actions are slower than state actions in this area. The Department must seek a temporary restraining order (TRO) and a preliminary injunction (PI) from a federal court to shut down a scam as well as to appoint a receiver, in federal cases called an independent fiduciary. 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. This means that in federal court, the Department must overcome a high evidentiary burden.

Unlike states shutting down illegal 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, Labor's investigations may take several years.

It is the policy of the Department not to inform the public that an arrangement is under investigation, even when an affected person notifies the Department that claims are not being paid. This means that many small businesses continue paying premiums to an insolvent or fraudulent entity and many new unsuspecting businesses sign up.

TRG — a multi-year investigation by the federal government

Hawaii and Kentucky's insurance departments issued orders to shut down TRG, a nationwide plan, in November 2001 (with at least 8 other states following). One state (Florida) had enough evidence against TRG's operators for a criminal indictment by a grand jury in 2003. Two years after the first state actions, the U.S. Department of Labor filed its civil complaint in federal court.

Because quick actions are important to prevent assets from disappearing, the Department is at a big disadvantage not having administrative authority to shut down illegal operations and to appoint independent fiduciaries. During the current cycle of scams, state insurance departments using their broad administrative authority and oversight strategies have shut down 41 illegal operations compared to the federal government's three.³⁶

While being investigated, operators of scams continue collecting premiums and misusing or embezzling assets. It is the policy of the Department not to inform the public that an arrangement is under investigation, even when an affected person notifies the Department that claims are not being paid. This means that many small businesses continue paying premiums to an insolvent or fraudulent entity and many new unsuspecting businesses sign up.

This policy is also very different from state insurance department practices. Through quick administrative actions the public is notified about the illegal status of an entity. Some states notify enrolled businesses that an entity is under investigation for being unlicensed, prior to issuing final cease and desist orders. For example, Nevada's Insurance Commissioner instructed the chief fraud investigator

to notify small businesses enrolled in Employers Mutual LLC that the company was under investigation before issuing a final administrative order to cease operations. This resulted in many small businesses finding other coverage and mitigating their losses.³⁷

Criminal Investigations and Enforcement

Promoters of AHP scams sell coverage in many states, move money across state lines, and in some cases hide assets off-shore. Consequently, there is a strong need for federal criminal investigations and court actions. At the federal level, law enforcement agencies such as the Federal Bureau of Investigations (FBI), the Internal Revenue Service (IRS), the Postal Inspection Service, and the U.S. Department of Labor’s Inspector General can conduct criminal investigations on AHPs. The primary investigative agency, however, is the U.S. Department of Labor’s Employee Benefits Security Administration (formerly PWBA). Until the early 1990s, EBSA did not conduct criminal investigations; its primary role was civil enforcement.

Until the early 1990s, most criminal AHP investigations were handled by the U.S. Department of Labor’s Inspector General.³⁸ In 1990, Secretary Dole instructed PWBA (renamed EBSA) to initiate formal training in criminal investigations.³⁹ The Inspector General warned Congress that:

“Even if PWBA wished to change its civil emphasis, it does not have, unlike OIG, any professionally trained and recognized (“GS-1811”) criminal investigators, people who know where to look and how to look for criminal activity — Special Agents who are adept at using standard investigative techniques such as electronic surveillance, search warrants, and undercover operations, and the development of informants and other confidential sources.”⁴⁰

To date most of EBSA’s cases remain civil. The Department reports that from 1990 to December 2004, it had initiated 621 civil cases compared to 107 criminal.⁴¹ In June 2004 it had 122 civil and 38 criminal open investigations.⁴² Based on this data, it appears that EBSA continues to be primarily a civil enforcement agency.

The Inspector General’s authority was restricted in 1990, limiting investigations to cases involving unions or phony unions.⁴³ The FBI has a designated unit for health care fraud. However, in recent years, its focus has not included AHP and other MEWA cases.

In addition to federal law enforcement agencies, state insurance departments have fraud units that conduct criminal investigations or work with state police on such investigations. However, due to jurisdictional constraints (authority in-state) and resources (a state may not have resources to send an investigator oversees, e.g., Cayman Islands, to find assets), federal investigations and prosecutions are necessary.

The federal government’s criminal enforcement record is mixed and few promoters of scams are indicted and even fewer serve time in jail. Absent aggressive federal criminal investigation and prosecution, promoters of scams after being shut down civilly move, change their names, and start a new scam.

The federal government’s criminal enforcement record is mixed and few promoters of scams are indicted and even fewer serve time in jail.

ERISA as a shield means proliferation of scams

Although Congress clarified ERISA twenty years ago, some ambiguities remain and operators of phony health plans continue to use ERISA's real and perceived ambiguities as a shield to avoid state enforcement actions. Some create complex legal documents that, at least on paper, raise questions about their legal status.⁴⁴ Others challenge state authority by removing state cases to federal court. In the case of American Benefit Plans covering 40,000 people nationwide and owing over \$28 million in unpaid medical bills, subsequent to a Texas state court action, promoters removed the case to federal court.⁴⁵

There are several implications when ERISA is used as a shield against state regulation. It is expensive for states to defend their authority, especially when cases are removed to federal court. One state spent half a million dollars litigating an ERISA preemption issue relating to a MEWA in the mid 1990s.⁴⁶ Additionally, while a case is litigated, operators of a scam continue collecting premiums and have an opportunity to spend or hide assets.

The "ERISA" problem is not a new one. In 1991, the U.S. Senate Permanent Subcommittee on Investigations found that operators of scams used ERISA as a way to avoid state oversight.⁴⁷ Ten years earlier, the U.S. House of Representatives Subcommittee on Labor-Management Relations of the Committee on Education and Labor found that criminals used ERISA against state attempts to regulate multiple employer arrangements, called "multiple employer trusts" at that time.

Congressional interventions

To date, there have been two significant congressional interventions — in 1982, the Erlenborn amendment clarifying that states have authority to regulate in this area and in 1996, HIPAA amendments to ERISA allowing the U.S. Department of Labor to require MEWAs to register. The Erlenborn amendment has helped regulators and investigators to better protect consumers by giving states authority over multiple employer arrangements. States have used their authority effectively, and the federal government has had a complementary role. It is too early to tell to what extent the 1996 amendments improve regulation. Below is a discussion of the difficulties the federal government has had with requiring MEWAs to register.

Federal Authority to Require AHPs and other MEWAs to Register

In response to the long history of financial instability and fraud promoted through MEWAs, in 1996 Congress expanded the Department of Labor's authority to allow it to require associations and other MEWAs to register with it. In part this was to help states and the federal government to learn where MEWAs are operating.⁴⁸

In 2000, the Department implemented the registration requirement by instructing MEWAs when to file and what information to provide to the federal government.⁴⁹ Seven years after gaining this authority, the Department finalized its regulation, making the final rule effective on January 1, 2004. In the final regulation, the federal government warned, however, “the Department is still in the process of implementing its civil penalty enforcement program to correct compliance failures.” (emphasis added)⁵⁰

A lack of an enforcement program is evident. In 2003, of the approximately 700 filings, over 100 forms had problems such as false claims that an arrangement was licensed by a state, incomplete or completely blank filings, and conflicting or incorrect information.⁵¹ Congress authorized the Department to fine multiple employer arrangements up to \$1000 per day for submitting incomplete or inaccurate filings or for not filing. As of 2004, the Department has not issued fines for violations of the registration requirements either against the MEWAs it investigated or against the MEWAs that filed Form M-1 with incomplete or inaccurate information.

Additionally, non-government researchers studying several AHP insolvencies reported that had MEWA filings by several AHPs been reviewed by the federal government, the impact of these insolvencies perhaps would have been mitigated or prevented. For example, in 2001, an association plan called the NJ Car Retailers notified the federal government that it was not complying with ERISA’s requirements and submitted a copy of court documents detailing its non-compliance along with its MEWA filing (Form M-1). In 2002, a court appointed receiver notified the Department that the association health plan was insolvent. The insolvent association left 20,000 people without health insurance and with \$15 million in unpaid medical claims. In 2001, another self-insured association health plan called the Indiana Construction Industry Trust notified the federal government that it had doubled in size in one year (based on comparing its 2000 and 2001 filings). This should have been a red flag for federal regulators about a potential problem — a self-insured association that doubles in size in one year may have solvency problems due to its rapid growth. This insolvency left 22,000 people with \$20 million in medical bills. Had the Department examined the filing and looked into the financial operations of this association health plan, perhaps the federal regulators could have prevented this association from becoming insolvent a year later.

Although the Department asked for authority to require MEWAs to register, it is not clear why it has not been able to use it effectively. Perhaps due to resource constraints or other reasons the U.S. Department of Labor has not been able to protect businesses and people covered by associations and other MEWAs reporting to it annually. The next section analyzes a congressional proposal to federalize regulation of association health plans.

Although the Department asked for authority to require MEWAs to register, it is not clear why it has not been able to use it effectively.

ANALYSIS OF AHP LEGISLATIVE PROPOSAL AND DISCUSSION

The full potential impact of H.R.525/S.406 is unknown. However, given its new preemption standard that is both broad and vague, a long history of scams, current scams promoted through associations, a mixed record on federal oversight, and resource constraints, this legislation is likely to have an unintended consequence — an increase in health insurance coverage scams.

This section analyzes one legislative proposal and its potential impact on preventing health insurance scams. The Small Business Health Fairness Act of 2005 (H.R. 525/S.406) would allow for federal licensing of qualified association health plans and exempt such arrangements from state oversight.⁵²

The full potential impact of H.R.525/S.406 is unknown. However, given its new preemption standard that is both broad and vague, a long history of scams, current scams promoted through associations, a mixed record on federal oversight, and resource constraints, this legislation is likely to have an unintended consequence — an increase in health insurance coverage scams.

H.R.525/S.406 creates a federal certification option for health coverage offered by qualified professional and trade associations. AHPs would not be required to seek federal certification. Those that do, once certified, would be able to operate nationally, to sell coverage to employers and individuals, and to be exempt from almost all state-based insurance regulations. The U.S. Department of Labor would be responsible for certifying and regulating AHPs. The bill would prohibit states from regulating AHPs. Additionally, the bill would preempt state actions that may have the effect of precluding companies from doing business with federally certified AHPs.

Broad preemption of state oversight: regulatory loopholes and preemption ambiguities

The legislation has several broad new preemption provisions that would preempt current authority that states have to regulate both association health plans and companies that conduct business with such arrangements. The new provisions if enacted would create oversight loopholes and new ambiguity under ERISA about the extent of the federal preemption and the authority of states to investigate and shut down AHP scams. Consequently, the bill would allow illegal entities to escape state regulation by selling coverage through federally licensed AHPs.

The legislation states:

“...the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.” (emphasis added)⁵³

This preemption provision would apply to state regulation of both licensed and unlicensed companies. By preempting state actions over unlicensed ones, the bill creates a significant loophole and opportunities for fraud. The preemption provision says that states cannot preclude health insurance issuers from

offering coverage to AHPs. The bill defines “health insurance issuer” using ERISA’s existing definition: “an insurance company, insurance service, or insurance organization ... which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance....”⁵⁴ The U.S. Department of Labor has interpreted this definition to include both licensed and unlicensed companies. According to the Department’s regulations, a health insurance issuer is:

“an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance....”(emphasis added)⁵⁵

The definition of health insurance issuer, therefore, includes companies that are licensed and those that are required to be licensed but are not. H.R.525/S.406 would preempt states from regulating both licensed and unlicensed insurance companies to the extent that state actions preclude a company from offering coverage to a federal AHP.

Consequently, this means that the bill would prohibit states from making it illegal for unlicensed companies to sell coverage to federal AHPs because such state law would preclude a company from offering health insurance to a federal AHP. This could expose consumers in federal AHPs to fraud. During the recent cycle of health insurance scams, legitimate associations such as the National Writers Union and the Wedding Event Videographers Association in Florida were defrauded by illegal arrangements.⁵⁶ In fact, selling to existing associations is one way that promoters of scams do business; it means enrolling lots of people quickly.

While preempting state law in this area, the bill is silent on how to address it at the federal level, creating a regulatory loophole. Although it is unlikely that Congress intends to prohibit states from shutting down illegal companies that sell coverage to federal AHPs, this would be the result of the preemption provision in the bill.

In addition, the bill would create an ambiguity in the scope of preemption. The term “has the effect of precluding” is vague and would make it difficult to determine which state laws and insurance department actions are preempted. For example, the bill would allow an insured AHP to sell nationally a policy approved in one state. Due to bill’s broad and ambiguous preemption provisions, it is uncertain whether the local insurance regulators would have the authority to verify that in fact the AHP policy was approved because such verification may have the “effect of precluding” a company from offering AHP coverage and thus be preempted. Additionally, the preemption provision would also make it difficult for a state to investigate.

The preemption term “has the effect of precluding” is not in ERISA’s current provisions, which have been litigated since ERISA’s enactment in 1974. The new language is both broad and imprecise and thus like other preemption questions is likely to result in litigation. Depending on budgets, states may not have the necessary resources to litigate these new legal questions. Even if they do, in this case, the new preemption language, raising a legitimate legal question for courts, also creates a new opportunity for criminals to use ERISA as a shield against state oversight. As discussed earlier, litigation means that criminals continue to operate, collect premiums, and not pay claims.

Consequently, this means that the bill would prohibit states from making it illegal for unlicensed companies to sell coverage to federal AHPs because such state law would preclude a company from offering health insurance to a federal AHP. This could expose consumers in federal AHPs to fraud.

Problems with specific provisions: repeat offenders; stop-loss insurance

No Prohibition Against Repeat Offenders Operating an AHP

There is no specific provision in the bill that would prohibit individuals, who have operated phony arrangements in the past or those who have been convicted of a felony, from controlling, owning, or managing an AHP.

There is no specific provision in the bill that would prohibit individuals, who have operated phony arrangements in the past or those who have been convicted of a felony, from controlling, owning, or managing an AHP. Currently, ERISA allows a federal judge at his/her discretion to bar (3 to 13 years) an individual convicted or imprisoned for certain types of crimes from holding certain positions in an ERISA plan.⁵⁷ Assuming this provision would apply to AHPs, one problem is that the prohibition is not mandatory or automatic, and it is not a permanent bar.⁵⁸

A more significant problem is the fact that there have been few felony convictions in ERISA health care fraud cases. During the recent cycle of fraud, while states and the federal government identified 144 illegal arrangements, few operators have been indicted and to date none have been convicted.⁵⁹

It takes years to build a criminal case involving health insurance fraud. For example, in a recent case in Texas, operators of several fraudulent schemes were in business from the early 1990s. Several of their operations were ordered shut down by state insurance departments throughout the 1990s. After more than a decade of defrauding businesses and their workers out of health insurance premiums, some of the operators were indicted by a federal grand jury in March 2004.⁶⁰ The AHP bill and current provisions in ERISA would not prohibit these operators from seeking certification as a federal AHP because they have not been convicted.

Another problem is that individuals who have been shut down by regulators for operating illegal arrangements avoid detection by recruiting other people to operate their new schemes. According to state and federal investigators, to avoid detection some operate “behind the scenes” using girlfriends, friends, and relatives to run new illegal companies. If the legislation were to be enacted in its current form, conmen and convicted felons would not be disqualified from obtaining a federal license to operate an AHP.

If the [AHP] legislation were to be enacted in its current form, conmen and convicted felons would not be disqualified from obtaining a federal license to operate an AHP.

Stop-Loss Insurance

As a way of background, the purpose of stop-loss insurance is to protect a self-insuring association from insolvency.⁶¹ The potential problem in the legislation is twofold: off-shore stop-loss insurers and mismanaged or phony AHPs.

One, historically there have been problems with some off-shore stop-loss insurers — not paying promised claims. Off-shore insurers have had a troubled history characterized by fraud and insolvency and have targeted ERISA covered employers.⁶² In a recent case involving off-shore companies, operators fraudulently collected \$45 million in premiums from businesses.⁶³ They now face a 54 count indictment, which includes money laundering and mail fraud and if found guilty, each defendant faces over 35 years in prison without parole.⁶⁴ According to federal prosecutors, “defendants usually referred to their victims as their ‘ERISA business’.”⁶⁵

When assets are off-shore and a company is in trouble, it is difficult to seize assets to pay legitimate claims. One of few ways to ensure that the stop-loss insurer is not a fly-by-night and is adequately capitalized is to require the company to be licensed in the United States (with assets in the United States). Although H.R.525/S.406 requires self-insured AHPs to have stop-loss insurance to help protect against insolvency, there is no requirement that the stop-loss insurer be a company licensed in the United States, with assets in the United States to pay claims.

The second problem is that the bill requires a stop-loss company to pay an AHP once coverage under the policy is triggered. The bill would prohibit a stop-loss insurer from paying medical bills directly to providers. In cases of mismanaged or AHPs operated fraudulently, this would be a financial windfall for unscrupulous operators of an AHP. More importantly, this would leave businesses and people covered by an AHP unprotected and potentially with millions of dollars in unpaid medical bills that should have been paid by stop-loss insurance and the AHP.

While the legislation appears to give the federal government some authority to establish additional standards for stop-loss insurance policies, the grant of authority is vague and limited. The bill says:

“stop-loss insurance means, in connection with an association health plan, a contract – (A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract (emphasis added).”⁶⁶

It is uncertain whether the Department would have authority to require stop-loss insurers to be U.S. licensed. This grant of authority is a parenthetical in a definition. Federal regulators may determine that they would not have authority to require insurers to be U.S. based. In the alternative, through rule-making, the federal government may impose a prohibition against off-shore companies. However, this may be challenged in court. In either case, the lack of a specific requirement in the legislation means that federal AHPs, their small business members, and covered people are at risk if off-shore stop-loss companies do not pay claims. Furthermore, the Department would not have authority to ignore the bill’s requirement that a stop-loss policy pay the AHP (even a mismanaged one). Again, this leaves businesses and their employees in AHPs unprotected financially and at risk for having to pay medical bills that should have been paid by an AHP.

Regulatory model: self reporting, self regulation, limitations on both federal regulatory and oversight authority, and restrictions on federal courts

Unlike with state regulation of insurance or federal regulation in other areas, the bill would establish a regulatory structure that relies on the accuracy of self-reported information, constrains regulators’ authority to verify the validity of the information, and limits federal regulators’ authority after problems occur. The bill would also limit the authority of federal courts. This type of model would create new opportunities for fraud and would leave many businesses and workers at the mercy of unscrupulous individuals.

Self Reporting and Self-regulation

"crooks do not file truthful forms" ⁶⁷

U.S. Department of Labor's Inspector General, 1990

This type of [AHP] model would create new opportunities for fraud and would leave many businesses and workers at the mercy of unscrupulous individuals.

The bill would require applicants for federal certification to file certain information with the Department and would not require or authorize the Department to conduct background checks or on-site pre-licensing investigations to verify that the information being reported is accurate.

State regulators with experience in regulating associations and other MEWAs believe that extensive pre-licensing investigations are important tools to help ensure that only qualified arrangements receive a license and to identify potential financial problems early.⁶⁸ Through extensive investigations, for example, California's regulators denied licensing to five of the 12 associations that requested licensing. State regulators in other states also have denied licensing to associations based on a verification, request for additional information, and on-site investigations yielding inconsistent or new information about the applicant association disqualifying it from state licensing.⁶⁹ Absent on-site investigations, relying on paper submissions may result in improper licensing and at worse expose businesses and their workers to financial liability for unpaid claims.

It is also not clear whether the Department would have the capacity or the regulatory authority to conduct on-site investigations or background checks. The self-reporting regulatory approach in the bill and a lack of specific authority (or requirement) for federal regulators to conduct on-site investigations prior to licensing would make it almost impossible for the federal government to prevent conmen from obtaining a federal license.

The bill also would use the same regulatory model — relying on self-reported information — once AHPs are licensed. For example, the Department's authority to close a self-insured AHP with financial problems largely depends on the AHP providing accurate and truthful information to the Department. The bill states that an AHP must cease operations when the Department:

"...has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements and ... that there is a reasonable expectation that the plan will continue to fail to meet the requirements...." (emphasis added)⁷⁰

This means that even if the Department had determined that an AHP's financial problems might cause it to fail, the department would be allowed to require AHP termination only if an association's board of trustees did not notify the department that corrective action had been taken by the board. This means that if the Department were notified *falsely* that corrective action had been taken, but in fact such action had not been taken, the department would not be allowed to administratively require termination.

A regulatory approach that relies on self reporting encourages unscrupulous individuals to make false reports to the government. If such individuals operated a federally licensed self-insured AHP, they would have no incentive to correct financial problems of an AHP. To the contrary, they would have a strong incentive to submit false reports to the federal government. If the Department wanted to

challenge the false report and to shut down the AHP, the bill would require the Department to go to federal court (see discussion below). This would delay termination and increase the risk that assets may be depleted, which would result in potentially more unpaid claims. A court action gives criminals time to deplete or hide assets.

The full impact of this type of regulatory approach is difficult to predict, but reliance on self-reported information is likely to lead to new opportunities for scams.

Unclear Authority of Federal Regulators over “Class” Certifications of Fully Insured AHPs

The bill may limit the Department’s authority over fully insured AHPs. The bill requires that “class” certification procedures be developed for fully insured AHPs while self-insured ones would have to be reviewed individually.⁷¹

The bill states that the government:

“...shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).” (emphasis added)⁷²

This provision raises a concern that the Department would not have authority to review each fully insured AHP filing. This language may mean that upon a filing of required paperwork and payment of a fee, the Department must automatically certify an AHP without any verification, investigation, or even a review of the submitted paperwork to ensure the information submitted by an AHP is accurate.

False claims about an association’s qualifications — even one that is fully insured — are not unusual. In a case that involved real insurance and an association established in 1992, a state judge found that its founder’s claims about the association were inaccurate. During administrative hearings looking into (among other issues) whether the association had a legitimate business purpose, its founder claimed that the association had thousands of members during a period of time it did not offer health insurance. The state judge found that the association did not have members during those years and that people joined it when they had bought its insurance. Contrary to the association’s claims, the judge determined that this association was formed for purposes of offering group insurance.⁷³

The bill’s “class” certification requirement seems to restrict the Department’s authority over fully insured AHPs. Consequently, the Department may inadvertently certify a phony AHP (whose records have been fabricated), one that has unknowingly purchased coverage from an illegal insurance company, or one that does not meet the minimum requirements.

A regulatory approach that relies on self reporting encourages unscrupulous individuals to make false reports to the government. If such individuals operated a federally licensed self-insured AHP, they would have no incentive to correct financial problems of an AHP.

An unintended consequence is that this creates a new opportunity for unscrupulous individuals. Being federally certified is akin to a seal of good housekeeping. Criminals would use their federal certification to attract customers, taking advantage of unsuspecting businesses.

Enforcement and Oversight: No New Administrative Tools

The legislation does not give the Department of Labor types of tools it would need to regulate effectively. For example, as discussed earlier, states can shut down a financially unstable or fraudulent arrangement quickly by using their administrative cease and desist authority while it takes years for the federal government to go to federal court. In one case involving a nationwide scam, it took the federal government two years to shut down the arrangement. Time is critical because operators of scams move, hide, or spend assets quickly. The bill would not authorize the federal government to administratively shut down a phony entity. Instead, H.R.525/S.406 would require the federal government to go to federal court. This coupled with preemption of state oversight is likely to result in more fraud. (See Appendix A Summary of State and Federal Oversight)

Limitations on Court Authority: Fully Insured Certified AHPs

The bill also limits the authority of courts to shut down a certified AHP that is in violation of its certification requirements. The bill states that a federal court could order a fully insured certified AHP to cease operations if it is no longer complying with federal standards except when:

"...with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514." (emphasis added)⁷⁴

This provision would prohibit a federal judge from ordering a certified AHP from ceasing operations even when it is violating federal standards.⁷⁵ An AHP seeking to avoid being shut down could easily show that it is "operating in accordance with applicable State laws that are not preempted." As discussed above, the bill would preempt most state insurance laws from applying to federally certified AHPs. There would be few state laws that are not preempted that a fully insured AHP would have to comply with. An AHP looking to avoid being shut down would only need to show that it is complying with those state laws. And consequently, the bill would prohibit a federal judge from ordering the AHP to cease operating even when it is violating federal law.

The bill would not give the Department of Labor specific authority to order administratively a certified fully insured AHP to cease operations. Absent judicial or administrative authority to order an AHP shut down, coupled with a prohibition on states from doing so, means a huge gap in oversight, which would leave businesses and workers covered by such AHPs unprotected against fraud.

Resource constraints

Resource constraints currently are a problem for the Department. This is evidenced by the high non-compliance rate with current health-related standards in ERISA, the Department’s enforcement and oversight limitations, and in its investigations. Additional responsibility under H.R.525/S.406 would further strain already scarce resources. Consequently, replacing state oversight with federal without adequate resources for federal regulators would mean businesses in federal AHPs would be unprotected against fraud.

The Department currently has 2.5 million health plans under its jurisdiction covering 131 million people. Of those, 275,000 are self-insured and are under the Department’s exclusive jurisdiction.⁷⁶ According to its own audits, for example, the Department found a 30.7% noncompliance rate with substantive requirements relating to health provisions in ERISA (a 45.3% noncompliance rate when notice requirements were considered).⁷⁷ This high non-compliance rate means that millions of ERISA covered people are not receiving federal protections. This could also be an indication that the Department’s enforcement and oversight strategy in part due to resource constraints requires significant improvements.

Additionally, resource constraints on federal regulators can be seen through enforcement practices. The Department currently does not go to court to enforce ERISA in cases of single violations. In fact, the federal government advises people seeking the Department’s help as follows: “Generally, we recommend to plan participants that they seek their own legal counsel.”⁷⁸ The Department allows a plan to violate ERISA as long as there is no pattern or practice of violations. This means that to enforce federal rights, employees and their families must go to federal court themselves.⁷⁹

Given the fact that there are 131 million people with health coverage governed by ERISA, it would be almost impossible for the federal government to help every consumer with a problem or to enforce the law in every case where there is a violation, absent extensive new resources.

The problem of resources can also be seen in the Department’s inability to enforce the MEWA registration requirement. As discussed earlier, it appears that the Department does not have resources to review approximately 700 annual filings nor to enforce the filing requirement.

Resource problems are also evident in its investigations. When the Department investigates both a criminal and a civil case, it means that at least two investigators must be assigned. This is because of the constitutional due process rights of a criminal defendant. One person cannot investigate both a criminal and a civil case. The Department’s resource constraints mean 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 the government to shut down a scam and to try to find assets to pay outstanding medical bills. A successful criminal action allows the government to put perpetrators of fraud in jail — the only way to stop them from repeating the scam. Resource constraints currently force federal investigators to choose between a criminal or a civil investigation in many cases where both are warranted.⁸⁰

Consequently, replacing state oversight with federal without adequate resources for federal regulators would mean businesses in federal AHPs would be unprotected against fraud.

Although it is clear that the [U.S. Labor] Department does not have resources it needs to effectively regulate and oversee plans under its current jurisdiction, it may not receive additional resources even if the regulation of AHPs is added to its responsibility.

Although it is clear that the Department does not have resources it needs to effectively regulate and oversee plans under its current jurisdiction, it may not receive additional resources even if the regulation of AHPs is added to its responsibility. The Secretary of Labor has indicated that the Department may not need new resources for the new regulatory responsibility should the legislation be enacted. Secretary Chao has testified that “We have the resources, and I am confident that if we do not, we will get the necessary resources....budget has been increased 10 percent in the fiscal year 2004, and a great deal of it goes to enforcement. And as I mentioned, I do not anticipate that we will have any problems enforcing this added responsibility....We already have that ability (a strong regulatory structure).”⁸¹ Secretary Chao has told Congress that few if any new resources would be needed.⁸²

In 1997, in evaluating a similar federal bill, the Assistant Secretary of Labor Olena Berg told Congress that given its resources and the scope of its regulatory responsibilities, the Department could review each plan under its jurisdiction once in 300 years. She said, “An infrastructure adequate to handle the new responsibilities (under a similar bill), replicating the functions of 50 state insurance commissioners, simply does not exist.”⁸³

Given significant budget deficits, even if the Department were to ask for new resources, it is unclear that funding the Department would be a priority given other domestic priorities, e.g., homeland security. A lack of adequate resources coupled with weak oversight authority could leave consumers in AHPs unprotected against fraud and insolvency.

Opportunities for Fraud: confusion over who regulates and lessons from history

The AHP bill would create a complicated structure, confusion, and uncertainty over whose responsibility it is to regulate arrangements providing coverage to multiple employers. If the bill were to be enacted, there would be different types of multiple employer arrangements in the marketplace because the bill would not require federal certification and would allow non-qualifying entities to operate. The bill also would not establish any qualifications or minimum standards (e.g., operating capital) for AHPs and other multiple employer arrangements not certified by the federal government.

Post Enactment of H.R.525/S.406: Regulation of Different Arrangement

ENTITY	FEDERAL OVERSIGHT	STATE OVERSIGHT
Federal AHPs	yes – AHP standards	no if fully insured, then one state’s standards (but limited authority)
AHPs that qualify for certification but choose not to become certified	yes – MEWA standards ⁸⁴	yes
AHPs that lose federal certification	yes – MEWA standards	yes
AHPs that do not qualify for federal certification	yes – MEWA standards	yes
AHPs falsely claiming to be federally certified ⁸⁵	yes – MEWA standards	yes – litigation and challenges to state authority likely
Federal AHPs that should not have been certified because they are phony	uncertain – AHP standards likely to apply, litigation is likely	no – states are preempted; litigation is likely
MEWAs (not federally certified AHPs)	yes – MEWA standards	yes
State licensed insurance companies that do business with federal AHPs	no	subject to state oversight unless preempted by the bill; litigation is likely
Phony insurance companies selling to federally certified AHPs	no	no – states are preempted; litigation is likely

Current: Regulation of Different Types of Arrangements

ENTITY	FEDERAL OVERSIGHT	STATE OVERSIGHT
MEWAs (including different types of AHPs)	yes	yes
Phony MEWAs (including phony AHPs)	yes	yes
State licensed insurance companies that do business with MEWAs (including AHPs)	no	yes
Phony insurance companies	no	yes

In addition to questions about state authority vis a vis federal, by creating two different licensing schemes for federal certification self-insured and fully insured AHPs, the legislation would create further confusion and opportunities for unscrupulous individuals. While the federal government would be responsible for self-insured AHPs, fully insured ones would be subject to federal authority and limited authority of one state. It would be up to the AHP and its insurer to decide which state's rules to comply with.⁸⁶ Having one state in charge of overseeing coverage sold in 50 other states is a recipe for no oversight. Insurance commissioners' oversight ends at their state borders; they do not have the jurisdiction or the resources to help consumers in other states.

Having one state in charge of overseeing coverage sold in 50 other states is a recipe for no oversight. Insurance commissioners' oversight ends at their state borders; they do not have the jurisdiction or the resources to help consumers in other states.

This structure would create 51 different regulators and sets of rules that scam operators could exploit to avoid regulation. When a state questions a fraudulent AHP, the unscrupulous operator could avoid regulation by claiming exemption as a self-funded AHP or claiming to be operating under the authority of another state. The bills' broad preemption provisions would restrict state regulators' authority to investigate such claims. As discussed earlier, a state would be preempted from shutting down an illegal company doing business with a federally certified AHP.

This regulatory framework has several implications. One, ambiguities in the bill would create confusion over oversight. A lack of clear standards for which regulator has authority to regulate could mean loopholes and no regulation of certain arrangements. Documented by Congressman Erlenborn's congressional hearings, in the past, confusion over oversight only helped criminals. Such confusion is an open door for criminals to invoke ERISA in every case where a state attempts to regulate the arrangement, even one that is not preempted by ERISA. Criminals in fact have nothing to lose by challenging state authority under ERISA. Such challenges always mean more time for criminals to operate and to hide assets. Also, new and broad preemption provisions would result in real legal questions for courts to resolve. While these are being litigated, there may be a vacuum where no one regulates.

Even in clear circumstances when the Department of Labor is the only regulator, historically, the result has been an inability to prevent fraud and insolvency. Federally certified AHPs would be considered "ERISA plans" and as such would be excluded completely from state oversight.⁸⁷ This regulatory structure — the Department being responsible for regulating ERISA plans and states' oversight over multiple employer ERISA plans prohibited — is the framework that Congress established in 1974. Back then, this oversight structure had unintended consequences resulting in fraud and insolvency. As discussed earlier, fraud and the inability of the federal government to protect people were some of the reasons Congress amended ERISA in 1982 to allow states to regulate multiple employer arrangements. Regulatory loopholes, ambiguities, and a lack of a strong federal regulator would encourage unscrupulous individuals to set up operations and would lead to more fraud.

CONCLUSION

As America's small business owners struggle to find affordable health insurance for themselves and their workers and in light of an influx in health insurance scams that prey on small businesses, legislative actions should seek to improve protection for small businesses and their workers. Businesses and workers expect their covered claims to be paid when they have bought insurance. They expect that when an insurer is insolvent, that they will be protected. They expect that government is watching out for them and is acting to prevent fraud and mismanagement by insurance entities.

While there are differences in philosophy about an appropriate level of government regulation, there should be no debate about fraud. Good public policy means accepting the fact that fraud is a problem and taking steps to eliminate it.

Since ERISA's enactment, there has been a long history of fraud with multiple employer arrangements, including association health plans. Any government intervention should be analyzed asking the question of whether the intervention would help alleviate problems or would create new opportunities for fraud, making this problem worse.

Unfortunately, H.R.525/S.406 would make the problem of fraud worse. New federal preemption creates opportunities for criminals to abuse it and to use ERISA as a shield against state oversight. It should be expected that criminals will use every possible legal argument to delay state actions. They will challenge state authority based on the new preemption language. Significant regulatory loopholes will mean that scams will flourish. Conmen will continue to operate, defrauding more victims, collecting premiums and leaving small businesses and their workers with unpaid medical bills.

Specific provisions in the bills mean an increased likelihood of fraud: ambiguous and broad new preemption standards, lack of standards for stop-loss insurance, no prohibition against operators of phony companies (shut down in the past) from qualifying for licensing, restrictions on the U.S. Department of Labor's oversight authority and no new administrative tools, restrictions on federal courts, reliance on self-reported information, a self-regulation approach, and lack of resources for oversight. Even if these problems were to be corrected, the creation of different types of arrangements and confusion over who regulates, would lead to new opportunities for criminal activity (as the lessons of history teach us).

While past Congressional interventions have been helpful to better protect America's small businesses and workers against fraud, the pending proposal is likely to expose businesses to more fraud. The consequences are predictable: bankruptcy, delayed or foregone medical care, and loss of coverage for America's small businesses and workers.

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Appendix A: Highlights of State and Federal Legal Tools/Strategies and Proposed Changes

STATE INSURANCE DEPARTMENT	U.S. DEPARTMENT OF LABOR	H.R. 525/S.406
Early Warning System to Identify Fraud		
Insurance Agents: <ul style="list-style-type: none"> ◆ “eyes and ears” ◆ required reporting of suspicious activity ◆ liability for selling phony coverage Consumer and provider complaints: <ul style="list-style-type: none"> ◆ investigations and automatic referrals 	Consumer complaints: <ul style="list-style-type: none"> ◆ investigation only if a pattern of complaints 	Preemption of states
Close an Illegal Arrangement		
Administrative actions (quick and low burden of proof): <ul style="list-style-type: none"> ◆ cease and desist orders ◆ asset recovery ◆ receiverships State court: <ul style="list-style-type: none"> ◆ asset recovery ◆ receiverships/conservator actions ◆ closure 	Administrative actions not available Federal court (high burden of proof and time intensive): <ul style="list-style-type: none"> ◆ asset recovery ◆ independent fiduciary (Receiver) ◆ closure (injunctions) 	Administrative actions restricted New restrictions on federal courts and preemption of state actions
Prevent Fraud		
Extensive pre-licensing investigations and ongoing examinations (market conduct and financial) Notice to public of illegal arrangements	Audits (each plan can be audited once every 300 years due to resource constraints) No notice until federal court action	Limited authority and restrictions No requirement to warn the public

- * The author would like to thank Kevin Lucia, J.D. for his assistance in researching congressional history for this report.
- 1 Testimony of Tyrone Fahner, Attorney General, State of Illinois (former Assistant U.S. Attorney and former Director of Illinois Department of Law Enforcement), before the Subcommittee on Labor-Management Relations of the Committee on Education and Labor House of Representatives, March 5, 1982, at 6.
 - 2 U.S. Senate Permanent Subcommittee on Investigations Report “U.S. Government efforts to combat fraud and abuse in the insurance industry” hearing focused on efforts at the state and federal level to detect and deter fraud and abuse in certain employer sponsored health benefit plans known as multiple employer welfare arrangements, or MEWAs. U.S. Senate Permanent Subcommittee on Investigations Report “U.S. Government efforts to combat fraud and abuse in the insurance industry” Senate Report 102-262, March 1992, at 17-18 (hereinafter Senate Investigation 1992).
 - 3 Senator Grassley, Statement, “Health Insurance Challenges: Buyer Beware” Senate Finance Committee hearing to investigate health insurance scams, March 2004.
 - 4 U.S. General Accounting Office, Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage, GAO-04-312 (Feb. 2004) (hereinafter GAO Scams Report).
 - 5 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).
 - 6 Some victims are left with hundreds of thousands of dollars in unpaid medical bills. See Brian Grow, *Health Insurance Scams That Will Make You Sick*, BUSINESS WEEK, Aug. 26, 2002, at 40 (hereinafter Business Week: Scams).
 - 7 The focus of this report is whether the federal legislation establishes a regulatory framework that is likely to result in more fraud. There are other studies examining the legislation’s potential impact on consumers through broad preemption of state-based protections, adverse impact on the private insurance marketplace, and whether the legislation is likely to help uninsured people and small businesses. See Mila Kofman and Karl Polzer, *Federal Association Health Plans — Will This Proposal Remedy the Health Insurance Crisis?* 5 POLICY, POLITICS & NURSING PRACTICE 167 (Aug. 2004); Linda Blumberg and Yu-Chu Shen’s, *The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis*, California HealthCare Foundation, January 2004; *Increasing Small-Firm Health Insurance Coverage through Association Health Plans and Healthmarks*, Congressional Budget Office (Jan. 2000) (available at <http://www.cbo.gov>); Congressional Budget Office, letter to the Honorable George Miller, Senior Democratic Member, Committee on Education and the Workforce, U.S. House of Representatives, June 18, 2003 (available at www.cbo.gov); Congressional Budget Office Cost Estimate: H.R. 660: Small Business Health Fairness Act of 2003 (as passed by the House on June 19, 2003), July 11, 2003 (available at www.cbo.gov); Beth Fritchen and Karen Bender, *Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers*, Mercer Risk, Finance & Insurance Consulting. Prepared for National Small Business United, June 2003.

- 8 Stephen Long and Susan Marquis, *Pooled Purchasing: Who Are the Players?*, HEALTH AFFAIRS, Jul./Aug. 1999, at 105, 107.
- 9 See Mila Kofman, Kevin Lucia, Eliza Bangit, and Karen Pollitz, “Associations: Is It time to Reexamine their Regulation?” (forthcoming Fall 2005). See also, Addison, et al. v. American Medical Security, et al, Case No. CL 00-01445 AB (Fla. Cir. Ct. 15th circuit May 22, 2002) (Final Judgment on Liability) (hereinafter AMS Final Judgment).
- 10 Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration before the Senate Labor and Human Resources Committee, Oct. 1, 1997, at 9-11 (hereinafter Berg Testimony). For a discussion of civil and criminal MEWA fraud cases handled by the U.S. Department of Labor, see U.S. Department of Labor, Pension and Welfare Benefits Administration, Employee Retirement Income Security Act Report to Congress for years 1994 – 1999 (hereinafter U.S. Department of Labor Reports to Congress).
- 11 GAO Scams Report at 4; Mila Kofman, Kevin Lucia, and Eliza Bangit, Proliferation of Phony Health Insurance: States and the Federal Government Respond, BNA Plus (2003) (hereinafter Kofman Report on Scams).
- 12 Press Release, May 10, 2004 US Attorney’s Office, “Three Affiliated with Employers Mutual Arrested for Operating Bogus Health Insurance Provider.”
- 13 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).
- 14 Total claims of \$47 million were filed with the Receiver by employers, patients, and providers. These include duplicate claims filed by both patients and providers. Interview Robert Loiseau, Court Appointed Receiver, American Benefit Plans, January 12, 2005 (hereinafter Loiseau interview).
- 15 Texas Petition for Temporary Restraining Order at 5-7, Texas v. American Benefit Plans et al., Cause No. GV200903 (Tx. D. Travis County Mar. 6, 2002) (hereinafter ABP Petition). They also created other associations. However, according to a court appointed receiver, coverage through these was not sold. These included 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. Loiseau Interview.
- 16 Operators of the International Forum of Florida Health Benefit Trust defrauded 43,000 individuals and left \$29 million in unpaid medical bills. They pleaded guilty to embezzlements, kickbacks, and money laundering. In the plea agreement they agreed to pay \$34.5 million in restitution to the victims. Peter Kerr, *3 Plead Guilty in Insurance Fraud Case*, New York Times, Dec. 30, 1992, at D3.
- 17 U.S. General Accounting Office, Employee Benefits: States Need Labor’s Help Regulating Multiple Employer Welfare Arrangements, GAO/HRD-92-40, page 22 (Mar. 10, 1992) (hereinafter 1992 GAO Report).

- 18 Ironically, this results in victims not being able to borrow money to repay providers due to bad credit. Additionally, because in some states insurance companies are allowed to use people's credit rating before issuing policies, e.g., auto and homeowner insurance, victims of health coverage scams are at risk of not being able to buy other insurance.
- 19 Testimony of Marie Almond, before the U.S. Senate Committee on Finance, Hearing "Buyer Be Ware" March 3, 2004.
- 20 Testimony of Joan Piantadosi, before the U.S. Senate Committee on Finance, Hearing "Buyer Be Ware" March 3, 2004.
- 21 See Letter to Small Business and Entrepreneurship Committee, U.S. Senate, January 31, 2003 from Mila Kofman (discussing the impact of scams on victims).
- 22 *Id.*
- 23 See ERISA § 514(a), 29 U.S.C. §1144.
- 24 ERISA plans include fully insured and self-insured plans — both plans are exempt from state insurance laws. Insurance companies selling health insurance policies to ERISA plans (also called fully insured plans) are not exempt from state insurance laws.
- 25 Testimony of Frank Damon, Chief Deputy Insurance Commissioner, California Insurance Department, before the Subcommittee on Labor-Management Relations of the Committee on Education and Labor House of Representatives, March 5, 1982, at 53.
- 26 *Id.* at 54.
- 27 Although there were no changes to Labor's jurisdictional authority, it 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, Pension and Welfare Benefits Administration, Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation 5 (1992) (hereinafter U.S. Department of Labor MEWA Guide).
- 28 To be an ERISA health plan, a plan has to meet requirements of an "employee welfare benefit plan" defined as: "plan, fund, or program ... established or maintained by an employer or by an employee organization, or by both ... for the purpose of providing for its participants or their beneficiaries (employees and dependents), through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits" Most MEWAs provide benefits to employees of their members and not their own employees, and thus do not meet the definition of an ERISA plan.
- 29 U.S. Department of Labor MEWA Guide at 1.
- 30 Testimony of Frank Damon, Chief Deputy Insurance Commissioner, California Insurance Department, before the Subcommittee on Labor-Management Relations of the Committee on Education and Labor House of Representatives, March 5, 1982, at 54.
- 31 Senate Investigation 1992 at 3-4.

32 ERISA § 3(40), 29 U.S.C. § 1002.

33 The registration requirement was enacted in 1996. Six years earlier, Labor Secretary Elizabeth Dole asked Congress for authority to require MEWAs to register with the Department. See 1992 GAO Report; David Horowitz, *Uncovered: Health Plan Fraud Leaves Workers in Lurch*, St. Louis Post – Dispatch, Aug. 21, 1990, at 6D (hereinafter Horowitz Article). In addition to these requirements, federal HIPAA portability and access rules amended ERISA and therefore apply to MEWAs.

34 Additionally, victims greatly benefit when states have authority to order payment for outstanding medical claims in lieu of fines typically paid to the state. In many cases, regulators with such authority have ordered this against agents who sold unauthorized health plans.

35 Loiseau Interview.

36 GAO Scams Report.

37 Kofman Report on Scams page 33.

38 According to the Deputy Inspector General of the U.S. Department of Labor, between 1982 congressional hearings into MEWA fraud and 1990, PWBA did not obtain any criminal indictments against MEWA operators. Testimony of Raymond Maria, Deputy Inspector General, U.S. Department of Labor, before the Permanent Subcommittee on Investigations, Committee on Governmental Affairs, United States Senate, May 15, 1990, at 5 (hereinafter Maria Testimony).

39 David Ball, Assistant Secretary, Pension and Welfare Benefits Administration, U.S. Department of Labor, Testimony before the U.S. Senate Permanent Subcommittee on Investigations hearing on “Fraud and Abuse in Employer Sponsored Health Benefit Plans,” Senate Hearing Transcript 101-799, May 15, 1990, at 80.

40 Maria Testimony at 6.

41 Testimony of Ann Combs, Assistant Secretary for EBSA, before the U.S. Senate Committee on Finance, March 3, 2004.

42 Fact Sheet on MEWA Enforcement, U.S. Department of Labor, June 30, 2004.

43 Raymond Maria, Deputy Inspector General, U.S. Department of Labor, had strong criticism of the Department’s efforts. He told congress:

“[I]t is clear that with the exception of the Office of Inspector General, very little, if anything, has changed at the Department of Labor with regard to criminal enforcement in all of the years in which PSI (Senate Permanent Subcommittee on Investigations) has maintained its interest in this subject. There is still an undue reliance on civil and administrative enforcement and a strong institutional reluctance to vigorously employ criminal remedies.”

He warned congress:

“Can State officials rely upon DOL’s Pension and Welfare Benefits Administration (PWBA) for needed criminal investigative support? I submit the answer is no, based upon PWBA’s track record as well as its enforcement strategy and procedures.”

Maria Testimony at 2 – 4.

- 44 For example, some claim to be collectively bargained union plans. Others claim to be a single employer. Yet others claim to be administrators for ERISA plans (claiming that funds from different ERISA plans are not co-mingled).
- 45 U.S. Department of Labor, Pension and Welfare Benefits Administration, Informational Letter to Jose Montemayor, Commissioner of Insurance, Texas Insurance Department, Mar. 18, 2002. *Texas v. Robert David Neal, et al.*, Case No. A-02-CA-220-SS, at 4-5 (W.D. Tx. May 22, 2002) (remanded to state court).
- 46 Kofman Report on Scams at 25; Loiseau Interview.
- 47 Senate Investigation 1992.
- 48 HIPAA added new section to ERISA Title 1 – 101(g) ; HIPAA Pub. L. 104-191; see 1992 GAO Report (discussing that a registration requirement would help address MEWA problems).
- 49 65 Federal Register 7152 (February 11, 2000).
- 50 68 Federal Register 17498 (April 9, 2003).
- 51 Kofman, Mila, Eliza Bangit, and Kevin Lucia, *Multiple Employer Arrangements: Another Piece of a Puzzle, Analysis of M-1 Filings*, 23 JOURNAL OF INSURANCE REGULATION 63 (Fall 2004).
- 52 Similar bills to preempt state oversight were introduced in the 1990s but opposed by prior administrations. David Ball, Assistant Secretary of Labor appointed by President George Bush, told the U.S. Senate in 1990, “In concept, MEWAs would appear to fill an important void in health-care availability. In practice, they may be subject to abuse. This is because they may have inadequate reserves, and therefore, be unable to pay claims. In the worse situation they may be run by individuals who bleed them dry through extraordinarily high fees and outright embezzlement.” Horowitz Article (Assistant Secretary of Labor’s Testimony before the U.S. Senate Subcommittee on Investigations). Seven years later, Olena Berg, Assistant Secretary of Labor appointed by President Bill Clinton, told the U.S. Senate Labor and Human Resources Committee, “While MEWAs may offer economy of scale advantages, their operation is often marred by entrepreneurs who market and operate them as Ponzi schemes. These operators unscrupulously promise health benefits, collect premiums from the employers for health coverage and then default on their obligations, leaving participants with thousands of dollars in unpaid claims.” Berg Testimony at 10.
- 53 H.R.525/S.406, Title II – Small Business Health Fairness Act of 2005, Section 2 (b) Conforming Amendments to Preemption Rules. (2) amending ERISA by adding new (d)(1) to ERISA Section 514.
- 54 ERISA 733(b)(2).

- 55 69 Federal Register 78764 (December 30, 2004).
- 56 Kofman Report on Scams at 25.
- 57 See ERISA section 411(a).
- 58 Interview Marc Machiz, former Associate Solicitor, Plan Benefits Security Division, Solicitors Office, U.S. Department of Labor, January 7, 2005.
- 59 US v. Claro et al, Criminal No. H-04-126 Unsealed Grand Jury Indictment March 30, 2004; LA Times, May 11, 2004, “Three Arrested in Health Insurance Scam” by Seema Mehta.; Florida Department of Financial Services Fraud Division Annual Fraud Report FY 2002-3 page 19.
- 60 See US v. Claro et al, Criminal No. H-04-126 Unsealed Grand Jury Indictment March 30, 2004.
- 61 Insolvency could result from a miscalculation of both frequency and amount of medical claims. Stop-loss insurance would pay for a portion of medical claims that exceeds what an AHP has agreed to pay. For instance, if expected claims are \$1 million with an aggregate attachment point for stop-loss of 110 percent, the stop-loss insurance policy would pay claims after they reached \$1.1 million. The AHP would be responsible for the first \$1.1 million.
- 62 In the early 1990s, as a part of its investigation into insurance fraud, the U.S. Senate specifically looked at off-shore insurers and the types of problems that can occur with off-shore companies. See Second Interim Report on U.S. Government Efforts to Combat Fraud and Abuse in the Insurance Industry: Problems with the Regulation of the Insurance and Reinsurance Industry. U.S. Senate Report No. 102-310, July 1, 1992.
- 63 US v. Claro et al, Case No. H-04-CR-126, Government’s Trial Memorandum, Dec. 20, 2004 at 1 (Southern District of TX, Houston Division).
- 64 Press Release, March 26, 2004 US Attorney’s Office, South District of Texas, “Eight Indicted in Multi-million Dollar Employee Health Care Insurance Fraud Scheme.”
- 65 US v. Claro et al, Case No. H-04-CR-126, Government’s Trial Memorandum, Dec. 20, 2004, at 5. Southern District of TX, Houston Division.
- 66 H.R.525/S.406, Title II (a) adding new Part 8 to ERISA, creating new section 806 (g)(1)(A).
- 67 Maria Testimony at 8.
- 68 Mila Kofman, Kevin Lucia, and Eliza Bangit, *Self-Insured MEWAs: Insolvency and Other Challenges*, The Commonwealth Fund (Spring 2004) (available at www.cmwf.org).
- 69 Id.
- 70 H.R.525/S.406, Title II (a) adding new Part 8 to ERISA, creating new section 809(b).
- 71 H.R.525/S.406, Title II (a) adding new Part 8 to ERISA, creating new section 802(e).
- 72 H.R.525/S.406, Title II (a) adding new Part 8 to ERISA, creating new section 802(e).

- 73 Addison, et al. v. American Medical Security, et al, Case No. CL 00-01445 AB, at 6, 17-18 (Fla. Cir. Ct. 15th circuit May 22, 2002) (Final Judgment on Liability) (hereinafter AMS Final Judgment). Under the federal proposal to qualify, an association would have to be in existence for three years, be organized and maintained for purposes other than obtaining health coverage, have periodic meetings, and be supported by member dues. Thus, according to the claims made by its founder, the Taxpayers Network would qualify for federal certification. Absent a pre-certification investigation or the type of investigation that preceded the court's ruling in this case, the Department of Labor would not be able to verify its information and the association would likely qualify for federal certification. Restrictions on regulatory authority would mean that the Department may certify associations that do not qualify for certification.
- 74 H.R.525/S.406, Title II, Section 2004 Enforcement Provisions Relating to Association Health Plans, amending ERISA section 502 by adding new subsection (n)(2).
- 75 Additionally, the reference to "any other arrangement" raises a question of whether in addition to certified AHPs, the bill would limit a court's authority over other types of arrangements. This question would also be subject to litigation.
- 76 Testimony of Bradford Campbell, Deputy Assistant Secretary for Policy, EBSA, before the Subcommittee on Labor, Health and Human Services, and Education Committee on Appropriations, April 2, 2004.
- 77 Health Disclosure and Claims Issues: Fiscal Year 2001 Compliance Project Report. U.S. Department of Labor Employee Benefits Security Administration, January 2003, Introduction.
- 78 U.S. Department of Labor, Employee Benefits Security Administration, April 22, 2004 Letter to a Consumer (on file with author).
- 79 This means that violators of ERISA are often not fined nor required to take corrective action. It also means that individuals covered by ERISA are forced to go to court. Under ERISA the only remedy in court is to get one's claim paid. There are no punitive, non-economic, or economic damages. In part due to this, it can be difficult to find an attorney. Also, this means that there is no accountability of intentional violations of federal law.
- 80 Kofman Report on Scams at 33.
- 81 Secretary Chao response to question from Rep. Velasquez. Hearing before the Committee on Small Business, House of Representatives, March 3, 2003, Serial No. 108-2, 92-561 (available at <http://www.access.gpo.gov/congress/house>)
- 82 The GAO has also criticized the Department's ability to regulate stating, "The operational weaknesses and broader management issues ... could affect its ability to effectively and efficiently carry out its responsibilities for enforcing ERISA's employee benefit plan provisions." U.S. General Accounting Office, *Pension and Welfare Benefits Administration: Opportunities Exist for Improving Management of the Enforcement Program*, GAO-02-232, at 3 (Mar. 15, 2002).
- 83 Berg Testimony at 6.

- 84 As discussed earlier, current federal standards applicable to MEWAs is limited.
- 85 For example, exempting federally licensed AHPs from state regulation may result in promoters of phony health plans claiming to be federally licensed. This occurred during the period before 1983, when unscrupulous operators of MEWAs claimed exemption from state regulation. The legislation tries to address this problem by adding a new penalty for falsely claiming federal licensing. H.R.525/S.406, Title II, Section 4 amending ERISA 501 by adding new subsection (b). It remains to be seen whether this would be an effective deterrent or penalty for criminal behavior.
- 86 This also has broad implications for participating businesses and their workers. An AHP and its insurer are likely to choose a state with fewest regulations. This means that the quality of coverage, e.g., requirement for adequate provider networks, is likely to be different and most likely worse and subject to fewer consumer protections. This also means that when a consumer has a problem, the state where the consumer lives would not have authority to help that consumer.
- 87 H.R.525/S.406, Section 2 (a) adding new Part 8 to ERISA, creating new section 812(b)(2).

Association Health Plans:

Loss of State Oversight
Means Regulatory Vacuum
and More Fraud

