

**Association Health Plans: Preemption of State Oversight
Would Place Consumers and Small Employers At Risk**

May 8, 2002

Eleanor Hill
Anne Schott

King & Spalding
1730 Pennsylvania Avenue
Washington, D.C. 20006

Contents

Executive Summary 3

Preemption of State Law for AHPs 7

History of Fraud and Abuse: MEWAs..... 11

History of Fraud and Abuse: Liability Risk Retention Act..... 21

AHP Proposal Would Reinvent MEWA Problems..... 24

Conclusion..... 30

Executive Summary

The Association Health Plan (AHP) provisions under consideration by the Congress ignore the lessons of history by creating new regulatory loopholes for some of the same types of plans that left consumers with millions of dollars in unpaid medical bills in the past – including some association-sponsored multiple employer welfare arrangements (MEWAs).

Rather than expand access to dependable insurance coverage, the AHP provisions would instead generate greater opportunities for fraud and abuse to flourish at the expense of the public. The AHP provisions would remove the broad protection provided by experienced state regulators and replace it with a limited, and clearly inadequate, federal regulatory framework. Previous legislation creating federal regulation of insurance in this area led to such extensive problems for consumers that it ultimately was repealed by Congress.

In recent months, state authorities have shut down numerous unlicensed insurers that attempted to mislead consumers and evade state regulation by false claims of ERISA preemption. Media reports have cited plans that were able to enlist 22,000 customers in 49 states, in one case, and 32,000 customers in 47 states, in another, before being shut down. The Secretary of Labor recently warned of “an increase in fraudulent behavior.” The AHP provisions would add fuel to this “fire” by prohibiting state regulation and leaving consumers at risk in an increasingly complex and dangerous area.

Legislative History

In 1974, the Employee Retirement Security Act (ERISA) exempted Multiple Employer Welfare Arrangements (MEWAs) from state insurance regulation and placed them under the

regulatory authority of the Department of Labor. The MEWA exemption was nothing short of disastrous for consumers. The General Accounting Office (GAO) has reported that, between January 1988 and June 1991, “MEWAs left at least 398,000 participants and their beneficiaries with over \$123 million in unpaid claims.” Congressional hearings in both the House and the Senate confirmed that:

- numerous individuals lost their homes, their credit, and sometimes lifesaving treatment because their claims had not been paid by MEWAs that had become insolvent;
- in many of those cases, the problem MEWAs had been sponsored through associations, such as builders associations, bar associations, and small business associations. Those same kinds of plans would today most probably qualify as AHPs under the most recent legislative proposal (H.R. 2563);
- unscrupulous plans used the 1974 preemption provision as a shield against state regulation and oversight, allowing them to misappropriate premium funds and generate huge profits for themselves; and
- although state officials reported numerous concerns and complaints from consumers to the Department of Labor (DOL), the federal response was far too little and too late to prevent plan failures and huge and personally devastating losses for consumers;

The Congressional hearings made it clear that the only way to limit fraud and abuse resulting from preemption of state regulation of these plans was to again allow states to regulate MEWAs, including those marketed through associations. Congress responded by amending the law to return regulatory authority to the states. The Department of Labor (DOL) also issued supplemental guidance to confirm state regulatory authority over most MEWAs, including plans that could qualify as AHPs under H.R. 2563.

Review of Current AHP Provisions

AHPs are fundamentally the same types of organizations as many MEWAs that have, in the past, been sponsored through associations. If exempted from state regulation AHPs would

pose the same kinds of unacceptable risks to consumers that were highlighted during the previous Congressional hearings.

H.R. 2563 would largely exempt Association Health Plans from state regulation. It would deprive consumers of the states' considerable experience in preserving the solvency of health plans, assuring fair marketing to consumers, requiring adequate life-time maximums, and enforcing other basic insurance requirements. In place of this extensive state regulatory framework, H.R. 2563 would give the U.S. Department of Labor (DOL) limited responsibility for certification and enforcement efforts regarding AHPs.

As of 1999, the Department of Labor was already responsible for enforcing ERISA requirements to protect the \$4.3 trillion of retirement assets owed to 90 million participants nationwide by over 700,000 pension plans. The Department also had responsibility under ERISA for 6 million health and welfare plans. DOL has testified that "Based on our investigative experience, we could review each pension plan once in 170 years and, if you include health plans, once in every 300 years. An infrastructure necessary to handle the new responsibilities, replicating the functions of 50 state insurance commissioners, simply does not exist."

In March, 2002, the General Accounting Office reported on weaknesses in DOL enforcement, noting that DOL had not determined the level of pension plan ERISA noncompliance because such an effort would require its current investigative staff "90 years to fully and accurately complete." The AHP exemption would add an open-ended number of health plans to DOL's current workload without correcting this lack of regulatory resources.

In the absence of any effective oversight of AHPs, consumers could find themselves victimized by two types of plans:

1. those promoted by fraudulent and sham insurance operators who divert premium dollars for lavish salaries and other perks and then quickly move on when the medical claims are submitted, or
2. those promoted by well-intentioned but inexperienced operators who lack the skills and resources needed to avoid insolvency in the extremely complex business of insurance.

In both situations, the state regulator, closely monitoring and enforcing compliance with state created rules, is the consumer's best "insurance" against disaster. The AHP provisions would deprive consumers of that valuable protection.

Conclusion

The AHP provisions would erase, at great cost to consumers, much of the progress that has been made in identifying and correcting regulatory loopholes over the years. Nothing in this legislation would prevent the same proliferation of plan failures and consumer losses that occurred when these types of organizations were last clearly exempt from state regulation. If anything, the complexity of the new AHP proposal, the broad accessibility provided by the Internet and other advances in information technology since 1974, and recent increases in fraudulent insurance schemes are likely to generate even greater problems for consumers than those experienced in the 80's.

As a result, consumers could once again find themselves largely unprotected and victimized by the type of widespread fraud and abuse that preceded action by the Congress and DOL to confirm the states' authority to regulate MEWAs, including AHPs.

Preemption of State Law for AHPs

Provisions included in H.R. 2563, the House-passed Bipartisan Patient Protection Act, would largely exempt Association Health Plans (AHPs) from state insurance regulation in an effort to make insurance more accessible to small businesses. While perhaps well-intended, the provisions ignore the repeated problems that insurance consumers have encountered when state regulation has been preempted or hindered as a result of federal law. The bill would create new and potentially disastrous regulatory loopholes for some of the same types of plans that created those problems in the past. Rather than expand access to affordable but also dependable insurance coverage, history suggests that the provisions, as written, would generate greater opportunities for fraud and abuse to flourish at the expense of the state regulated insurance industry and ultimately, the public.

H.R. 2563 would amend the Employee Retirement Income Security Act of 1974 (ERISA), in effect exempting health insurance plans called AHPs from state regulation. AHPs are defined as certified group health plans that are sponsored by associations. For a plan to be certified, the sponsoring association must have been in existence for at least three years for purposes other than providing health insurance coverage and the plan must be operated by a board of trustees with fiscal control and responsibility for all operations.

Under the bill's provisions, self-insured, certified AHPs would be completely exempt from regulation by state insurance commissioners. These key state regulations typically include rules that assure fair health insurance premium rates, such as requirements for prior state review and approval of rates. AHPs would also be exempt from state rules that ensure the solvency of health plans, such as on-site exams by state insurance commissioners, as well as state

requirements that plans participate in reinsurance programs. Likewise, AHPs would be exempt from state rules that assure fair marketing, such as the mandatory review and prior approval of the plan's marketing and advertising materials. Importantly, AHPs would also be exempt from state regulations that assure health plans cover certain benefits. For example, AHPs would not be required to comply with rules that ensure adequate life-time maximums, reasonable caps on inpatient hospital stays and other state consumer mandated benefits.

In place of these extensive state regulations, the U.S. Department of Labor (DOL) would have responsibility for certification, oversight, and enforcement activities relating to AHPs. Unlike previous AHP legislation, H.R. 2563 no longer permits the Secretary of Labor to delegate that authority to a state, even if he or she concludes that state regulators are far better equipped to oversee a particular AHP. At most, the Secretary will "consult with" only a single state regarding its authority over an AHP, even if that AHP operates in a large number of different states.¹ Given the scope of operations of these kinds of plans, that limitation could prove disastrous. According to published reports, state regulators recently took action to stem losses where plans were offered through unlicensed insurers that had used claims of federal preemption and connections with various "associations" to convince consumers to buy their product. The plans were able to enlist 22,000 customers in 49 states, in one case, and 32,000 customers in 47 states, in the other, before finally being shut down.² H.R. 2563's federal preemption provision, coupled with its limitation on federal access to state authorities, would only increase the confusion that allows these kinds of plans to operate in essentially a regulatory vacuum.

In order to receive and maintain certification under H.R. 2563, a self-insured AHP must meet some reserve and minimum surplus requirements. The AHP must demonstrate reserves in an amount deemed adequate by a qualified actuary engaged by the plan's board and also

maintain a surplus of at least \$500,000, but not more than \$2,000,000, regardless of the size of the AHP. Alternatively, the Department of Labor may permit the AHP to substitute for these requirements security, guarantee, or other suitable financial arrangements evidenced, for example, by a letter of credit.

Under the bill, federal oversight of those solvency standards is totally dependent on self-reporting of financial conditions by the AHP. The board of each AHP is required to determine quarterly if these reserve and solvency requirements are met. If there is a failure to meet requirements, the board must notify its actuary and request recommendations for a corrective action plan. The board is not required to notify the Department of Labor until 30 days after receiving the actuary's recommendations, which could be as much as 90 days after first discovering the problem. If the Secretary of Labor determines that the AHP is unable to provide benefits, then the Department can seek a court order appointing the Secretary as trustee to administer the plan for the duration of the insolvency.

While the bill does not require that AHPs operate as fully insured plans, it nevertheless precludes state regulation of AHP plans that are fully insured. States are restricted in how they can regulate entities that issue health insurance coverage to certified fully-insured AHPs. The bill's provisions on reserves, surplus, stop-loss insurance, contributions to the AHP fund, and DOL's termination authority apply only to self-insured, certified, AHPs and not to fully insured, certified AHPs. Despite the absence of any substantial federal oversight authority, the bill supersedes "any and all State laws" that would have "the effect of precluding a health insurance issuer from offering health insurance" in connection with either a fully insured or a self insured, certified, AHP. Under ERISA, a health insurance issuer must only be licensed in "a State," but not necessarily in the state in which it does business. Thus, an insurer licensed in only one state,

could sell insurance to a certified, fully insured AHP in any another state, and be insulated from both state regulation in the states where it does business as well as the federal solvency standards, which apply only to self-insured AHPs. Under H.R. 2563, once any state approves a filing of the policy form for the policy type to be offered by any certified, fully insured or self-insured AHP, all other states would be prohibited from imposing any of their own requirements on similar filings made in those states, even if the plans conduct substantial business in those other states.

Clearly, these provisions suggest that the Department of Labor will create, staff, and maintain a new certification and regulatory mechanism in addition to its existing workload. To be effective, the Department of Labor would be required to develop and operate comprehensive regulatory programs, a task that is now the job of fifty state insurance commissioners and fifty well-developed and considerably experienced staffs. To conduct any meaningful oversight of AHPs, the Department of Labor would need to hire experts to develop the program and train numerous actuaries and auditors to operate the program, as well as a full staff including customer service positions to implement the certification program. The verification, investigative and enforcement costs would also be enormous, and could also impact workloads and resource levels of the Department of Justice, including the United States Attorneys' Offices. Clearly, these significant new federal responsibilities would require a great deal of additional resources. While AHPs would be required to pay an initial \$5,000 filing fee to cover certification costs, this is inadequate to fund a broad regulatory effort. No additional funding is included in the legislation to allow the DOL to establish the staff necessary to fulfill this new responsibility or to sustain the Department's role over time.

History of Fraud and Abuse: MEWAs

Given the scope of those provisions, history suggests that AHPs would operate in a largely unregulated and potentially disastrous environment. In the past, federal preemption of state insurance regulation was repeatedly used by health insurance plans known as Multiple Employer Welfare Arrangements (MEWAs) as a shield to frustrate efforts to detect and prevent fraudulent and abusive practices. Effectively insulated from state regulation and undeterred by the Department of Labor's oversight authority under ERISA, MEWAs too often generated huge profits for sophisticated con artists and untold losses for unsuspecting and unprotected policyholders.

A MEWA is defined as an employee welfare benefit plan or similar arrangement, including a health plan, established or maintained for the purpose of offering or providing benefits (other than pensions) to employees of two or more employers. AHPs covered by H.R. 2563 are currently considered to be MEWAs, given the Department of Labor's view that "a plan sponsored by a group or association of employers that provide benefits to the employees of two or more employer-members" is a MEWA.³

In 1974, Congress designated MEWAs to be covered by the provisions of ERISA and the authority of the Department of Labor and therefore, exempt from state insurance regulation. In the 1970s and early 1980s many MEWAs, and similar entities known as Multiple Employer Trusts (METs), marketed their plans to small businesses, used ERISA to avoid state regulation, mismanaged and diverted plan assets, and, as a result, became insolvent. In the absence of state regulatory efforts, Federal regulation of these plans by the Department of Labor proved largely ineffective. Fraud, abuse and mismanagement grew to the point where Congress took action to

correct the problem, enacting the 1983 amendments to ERISA that specifically gave state insurance regulators the authority to oversee MEWAs, including ERISA covered association health plans.

The AHP provisions would effectively repeal that amendment by again clearly exempting a number of these same kinds of plans from state regulation. Currently, association plans that serve multiple employers may be defined as MEWAs under ERISA and are still subject to state regulation. Association health plans not covered by ERISA can also be subject to state insurance regulation. Association plans in both categories would be largely exempt from state regulation as certified AHPs. This would effectively return the small business health insurance industry to the 1970s and early 1980s when fraud, abuse and mismanagement left hundreds of thousands of insured employees with millions of dollars in unpaid medical bills. That conclusion is strongly supported by the records of Congressional hearings in the House in 1982 and in the Senate in 1990.

1982 House Hearings

In early 1982, the House Subcommittee on Labor-Management Relations held a hearing, presided over by Rep. John Erlenborn (R-Ill.), “to record the facts behind the severe problems caused by the operators of so-called multiple employer health trusts.”⁴ Insurance commissioners from several states testified about the problems confronting the states because they were barred by ERISA from regulating failing MEWAs:

[I]ndividuals. . . will initially set up associations, claim that they are associations that are offering health plans -- the fact that they don't qualify under any of Labor's rules and are ultimately determined not to be valid trusts, it doesn't really matter to them because that determination will come a year or two, or more, down

the road. . . [The] preemption clause is rather ambiguous and it is rather broad, and anybody, regardless of their intention, can use it for these purposes. . .⁵

Much of the hearing testimony focused on the failure of two MEWAs. Our review of these cases reveals the potential dangers that could again exist if the AHP provisions were enacted. Both failed plans could have also claimed to be exempt from state regulation as an AHP, and probably would have qualified as AHPs, under the provisions in H.R. 2563.

The first, the Small Business and Independent Trades Association (SBIT), marketed health insurance to members of bar associations and their employees. To bolster its credibility, SBIT represented that it was underwritten by a reputable insurance company, which was not accurate. At the hearings, one practicing attorney testified that he joined the SBIT plan through the local bar association, believing the plan to be underwritten by a licensed insurance company.⁶ The attorney was left with \$143,000 in unpaid claims after his wife gave birth to a premature set of twins, and later was informed that SBIT was insolvent.⁷ At the time of the House hearings, it was estimated that SBIT operated in several states and was insolvent by as much as \$800,000 to \$1 million. A plan such as SBIT would likely qualify as an AHP since bar associations are usually bona fide professional associations that would meet the requirement of operating for at least three years for purposes other than providing health insurance coverage.

Testimony in the House Hearings also addressed a phenomenon called “rollovers.” Because states could not immediately intervene when they received complaints about a plan, plans had often become insolvent by the time the Department of Labor became involved. In the meantime, plan operators opened a new plan to perpetrate the same fraudulent scheme again under a different name.

State insurance regulators testified that they had received complaints about a health plan named Illinois Health Care Association Benefit Plan that purportedly was exempted from state regulation by ERISA.⁸ The state insurance department had no choice but to refer the case to the Department of Labor. The Department took a full year to determine that the plan was not an ERISA-covered plan.⁹ Shielded from any effective regulation, the plan became insolvent, owing nearly a half-million dollars in unpaid claims.¹⁰ In the meantime, the same individuals who operated the failed plan created an identical plan under a new name that provided health insurance to employees of 82 nursing homes across Illinois.¹¹ Not surprisingly, the new plan also became insolvent, leaving thousands of nursing home employees with over \$400,000 in unpaid medical bills.¹²

A California state insurance commissioner testified that, fueled by the federal preemption of state regulation, this “rollover” phenomenon was widespread.

Six times since 1977, a phenomenon known as rollovers occurred. In this situation, a trust is established, members assigned to that [sic], money is paid into the trust. Then we come knocking on the door due to complaints for non-payment of the claims which, by the way, does account for the vast majority of complaints we receive. The [trust] then shuts it [sic] doors and probably within hours either down the street or in another part of the State, another office is open, new forms are printed and the closed [trust] has now rolled over into a new [trust] with a new name, new forms, a new office, and they generally take the good risks that they wanted from the old trust . . . [w]e have run into some incredible delaying tactics which have allowed questionable [trust] to operate. In every instance that the [trusts] 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.¹³

The House hearings made it clear that the only way to stop this fraud and abuse was to allow states to regulate MEWAs, including those marketed through associations. Responding to the hearing testimony, Rep. Erlenborn and Rep. Philip Burton (D-Cal.) proposed legislation, which was enacted in 1983, that created an exception to ERISA that specifically permitted the regulation of MEWAs under state insurance laws.

1990 Senate Hearings

In May, 1990, the Senate's Permanent Subcommittee on Investigations, as part of a lengthy investigation of fraud and abuse in the insurance industry, held hearings focused on the use of MEWAs following the enactment of the Erlenborn-Burton Amendments. Unfortunately, the testimony quickly confirmed that little had changed since the 1982 House hearings. Ambiguity and confusion regarding the law had allowed, in Chairman Sam Nunn's (D-Ga) words, "...the promoters of fraudulent plans to operate in a twilight world somewhere between State and Federal regulation, often playing one set of regulators against the other."¹⁴

Given the complexity of ERISA and the Erlenborn-Burton amendments as well as the absence of any clear regulatory guidance, problem plans, including many sponsored by or otherwise linked to associations, had succeeded in impeding state regulatory scrutiny by claiming preemption under ERISA. With little or no information provided by the Department of Labor, state authorities were often forced to pursue lengthy and costly litigation to determine a plan's status. In the interim, problems with mismanagement, insolvency and fraud multiplied in the absence of regulatory oversight. Ultimately, regulators would determine that either the plan was not a MEWA and not subject to ERISA or was a MEWA but was still subject to state regulation under the Erlenborn-Burton amendments. Unfortunately, in the time it took to

confirm the state's regulatory authority, the damage had been done. Through mismanagement and, in, many cases, blatant fraud, the plans had become insolvent, leaving millions of dollars in unpaid claims.

The Subcommittee received testimony from the National Association of Insurance Commissioners (NAIC) as well as insurance regulators from ten individual states (California, Florida, Georgia, Kentucky, North Carolina, Ohio, Oklahoma, Texas, Virginia, and Washington), all of whom confirmed the continued severity of fraud and abuse among MEWAs. All reported that unscrupulous MEWA operators routinely used the ERISA preemption provisions and the complexity of the Erlenborn-Burton Amendments as shields against state regulation, generating huge profits for themselves and millions of dollars in losses for unsuspecting and unprotected policyholders, e.g.:

What became apparent in the hearings about abuses visited on the small employer in the late 1970's and 1980's is again being dramatized a decade later. Jurisdictional regulatory ambiguities invite entrepreneurial if not fraudulent alternatives. Many small employers, lacking the expertise and desperate to deal with plan cost, are turning to these arrangements on the erroneous assumption that they are safe, either regulated by the insurance department, or adequately protected under Federal law. Too frequently, after the loss of thousands of dollars, these small businesses, their employees and their families learn the painful truth that many such plans were deliberately designed to avoid State regulation and yet were never subject to any meaningful Federal oversight.¹⁵

... [N]ew schemes are multiplying right now like cancerous cells. Some might view this as an academic exercise, finger pointing or a turf battle, but it is none of these. Flesh and blood human beings are being hurt every day. Thousands of Texans alone are hurt. Only the amounts and names are different. ERISA has created a witches' brew of nonregulation and limited oversight that leads to buck-passing and inaction.¹⁶

MEWAs have been represented as a viable and less expensive health care benefit alternative to insurance or membership in an

HMO. MEWAs, it is claimed, make these benefits available and affordable to many Floridians, especially those in small businesses...Unfortunately, the overall picture in Florida is less favorable. It is our conclusion that dual regulation, which in some cases and at some points in time has actually been dual nonregulation, has resulted in extreme hardships to many consumers. Consider in the 7 years following ERISA's enactment...the Florida Department of Insurance detected more than 25 health programs which claimed to be ERISA employee welfare benefit plans that were in fact unauthorized insurers. A total of seven of these plans became insolvent, leaving Florida policy holders with millions of dollars in unpaid claims...And finally, while authorized MEWAs have a bad track record...the unauthorized bogus operations are even more insidious. They come into our State selling health insurance at what they say is a cut-rate price, but what they are really selling is illegal insurance offered by a company that is not licensed to do business in Florida, and they do this by throwing up a smokescreen that they are federally sanctioned ERISA's.¹⁷

The type of rampant fraud and abuse that occurred is best illustrated by a few of the very vivid case examples found in the Senate hearing record. One case involved a California based MEWA that enrolled thousands of insureds in Florida, Texas, and other states. Many of the insureds probably assumed the plan to be "safe" because it was sponsored by a bona fide trade association. The plan's operators persistently "stonewalled" state regulators by claiming federal exemption from regulation, and ultimately left unpaid claims of \$3.2 million. After the plan's demise, it was discovered that its two operators had each received approximately \$40,000 a month in salary and, insulated from any regulatory scrutiny, had spent insureds' contributions on such things as jewelry, tailor made suits, luxury cars, servants, home remodeling and personal credit card bills. At the time of the hearing, the corporation had been dissolved with no assets and the principals could not be located. Its victims included people like a Texas bank employee left to cope with not only the tragedy of a baby daughter born with congenital birth defects but also more than \$340,000 in medical bills.

Another MEWA, using the name “Christian Organization Medical Society,” successfully targeted its business at ministers, churches, and church schools. Its operators frustrated and delayed state regulators by claiming the ERISA preemption of state regulation and generated extensive litigation. The MEWA ultimately left \$5.4 million in unpaid claims. Only later did regulators discover that the insureds’ contributions had been spent on such things as the plan operator’s \$800,000 mansion, 500 acres of prime farm land, longhorn cattle, and exotic automobiles. Victims included the pastor of a small church left with \$200,000 in unpaid claims for the treatment of his baby, born with underdeveloped lungs. The pastor lost his home, his car, and his job. The plan’s operator, who had previously run another failed plan, was eventually convicted of mail fraud.

Finally, a MEWA set up within an employee leasing company took in approximately \$275,000 a month in premiums from insureds. The insureds were attracted by the reputation of a well-known national insurance company whom most believed to be the insurer based on statements by MEWA representatives and the use of the insurance company’s name in plan materials. In fact, the insurance company only contracted to provide administrative services for the plan, which was self-funded. Ultimately, the plan took the legitimate insurance company for over \$860,000 in claims it had paid and left another \$1,300,000 in outstanding claims. At the Senate hearing, the president of the employee leasing company invoked the Fifth Amendment privilege and declined to answer when asked what had happened to the premium monies collected by the plan. The insured victims included a salesman facing “bankruptcy and financial ruin” as a result of \$264,000 in unpaid bills for the treatment of his young daughter for leukemia. At one point, the two and a half year old girl came near death when the hospital treating her stopped testing needed to prepare the toddler for a life-saving bone marrow transplant. The

hospital staff told the parents this treatment was stopped because the insurance company had made no payments.

The Subcommittee directly addressed these kinds of cases in its March 1992 Interim Report on Combating Fraud and Abuse in Employer Sponsored Health Benefit Plans:

It was the 19th century French journalist Alphonse Karr who first said, “the more things change, the more they remain the same.” In the area of MET and MEWA fraud, this description seems particularly appropriate. Despite the efforts of Congress to solve the MET problems of the late 1970’s and early 1980’s through passage of the Erlenborn Amendment, the MEWA problems of the late 1980’s and early 1990’s have shown that little, if anything, has really changed.

For almost 18 years now, con-men, 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.

...Congress should amend ERISA to expressly provide that ERISA shall not be deemed to preempt the authority of individual states to require the licensure of all MEWAs.¹⁸

In a separate review of these issues in March, 1992, the General Accounting Office confirmed that the cases highlighted in the Senate hearings were symptomatic of a national problem with fraud and abuse in MEWAs. GAO reported that:

MEWAs have proven to be a source of regulatory confusion, enforcement problems, and, in some instances, fraud. Between January 1988 and June 1991, MEWAs left at least 398,000 participants and their beneficiaries with over \$123 million in unpaid claims and many other participants without insurance. More than 600 MEWAs failed to comply with state insurance laws, and some violated criminal statutes.¹⁹

Following the reports by the Subcommittee and GAO, Senator Nunn, in 1993, and again in 1995, introduced legislation intended to erase any doubt that the States had the authority to regulate all MEWAs. Although those proposals were not enacted, the Department of Labor, which had provided testimony during the Senate hearings, recognized the gravity of the MEWA problem and issued written clarification of the statutory provisions in order to facilitate state regulation of MEWAs. After many years and great cost to small businesses and their employees, the need for state regulation of MEWAs was apparently accepted. In March, 1999, the Commissioner of Insurance for the State of Maryland, testifying on behalf of the NAIC, confirmed that expanded state efforts to regulate MEWAs have had, with the Department's support, greater success in recent years:

The states and DOL, working in an ongoing cooperative relationship, have made great strides to curtail fraudulent activity and maximize the effective regulation of MEWAs.²⁰

The Commissioner did note one continuing area of abuse: “unscrupulous operators forming sham unions for the sole purpose of selling health coverage to unsuspecting multiple employers.” Not surprisingly, this area was not addressed by the 1983 amendments. The amendments focused only on MEWAs, amending ERISA to provide that they were subject to state regulatory authority. Under the terms of ERISA, however, plans established or maintained pursuant to collective bargaining agreements are not MEWAs and remain exempt from state regulation. As such, “sham unions” of the type described above can attempt to avoid state regulation by claiming ERISA's preemption of plans established by a collective bargaining agreement. Recognition of this issue has led the Department of Labor to develop clarification regarding states' authority to regulate sham unions.

Despite these efforts, recent reports suggest that the long and ambiguous history of federal preemption in this area continues to give unscrupulous operators of fraudulent plans the means to mislead consumers and avoid, or delay, the protections afforded by state regulation. The Texas Insurance Department, for example, alerted consumers as recently as March 15, 2002 to be wary of unlicensed health plans that claim to be “shielded from state licensing and regulation” by ERISA and “offer bargain- basement premiums but inevitably vanish when claims start piling up.”²¹ Reportedly, Texas regulators have, in the last twelve months, shut down four unlicensed plans that had promised coverage to over 20,000 Texas employees and their dependents.²² Given these and other recent reports of abusive plans, the Secretary of Labor last month publicly noted the “increase in fraudulent behavior” regarding MEWAs.²³ If anything, cases like this underscore the need for even stronger federal affirmation, as opposed to preemption, of state regulatory authority.

History of Fraud and Abuse: Liability Risk Retention Act

The MEWA experience, although especially relevant in the area of health insurance, is not the only example of the problems that have surfaced when federal law has preempted or limited state regulation in the insurance industry. In written testimony submitted for the 1990 Senate hearings, the General Counsel for the Kentucky Department of Insurance observed that:

...some federal laws which provide exemptions from state insurance regulation all too often serve as an invitation to persons engaged in fraudulent business practices. The preemption provisions of 29 U.S.C. 1144 [ERISA] and the Liability Risk Retention Act, 15 U.S.C. 3901 et seq., are two examples which come readily to mind. The Department urges the Congress to give greater consideration to preventing the possibility of creating avenues for fraud when state insurance laws are preempted by federal laws.²⁴

During the course of its review of fraud and abuse in the insurance industry, the Senate Permanent Subcommittee on Investigations also reviewed the impact of the federal Liability Risk Retention Act. That Act largely preempts state insurance regulation with respect to the purchase of liability insurance through Risk Purchasing Groups.

Although a different type of insurance is involved, the Act bears a striking similarity to the proposed AHP provisions in several ways. The Act was intended to facilitate the purchase of insurance by groups of firms or individuals engaged in similar business. It was prompted by a well-intended concern that this kind of insurance was no longer easily available to these kinds of businesses. The Act's provisions preempted much of the states' customary insurance regulations with respect to Risk Purchasing Groups and their insurers. Finally, it allowed these kinds of groups to acquire insurance from insurers not licensed and not regulated within their state.²⁵

As with MEWAs, the Subcommittee held hearings, in 1991, that assessed the impact of the Act on fraud and abuse in the sale of liability insurance. Witnesses included state and federal regulators, representatives of the Federal Bureau of Investigation (F.B.I.), and individuals who had been victimized by fraudulent insurance schemes. The story was a familiar one, as typified by the testimony of the Georgia Commissioner of Insurance:

To circumvent various State licensing requirements, the ...programs were marketed through purchasing groups ostensibly established under the Federal Risk Retention Act...Both ERISA and the Risk Retention Act created exemptions from certain State insurance laws, especially in the areas of licensing and financial regulation. These exemptions have been exploited by unscrupulous operators, and although some of these gaps have now been filled by changes in both State and Federal laws, substantial harm has been done.²⁶

Ryles and other witnesses described the case of an insurance company that had its policies marketed through purchasing groups established by “the Federation of Business and Professional Associations, International.” Pursuant to the provisions of the Federal Act, the company was licensed in only one state and yet within an 18 month period of operations, wrote policies for Risk Purchasing Groups across the United States, including the American Lawyers Liability Group; the American Truck Stop Operators Association; the Asbestos Abatement Contractors Association; the Child Care Center Association; the Liquor Dealers Association; the National Association of Horse Owners and Breeders; the Nursing Home Association of America; the Outpatient Service Providers Patient Protection Group; and the Southeastern CPA Risk PG, Inc. Through its sports disability program, the company issued coverage to over 200 professional and college athletes and teams across the country, including a number of prominent sports celebrities who provided testimony to the Subcommittee.²⁷

The company took in approximately \$16 million in insurance premiums during the 18 month period. At the time that it was placed in receivership, there was \$691,000 in remaining assets but \$20 million in outstanding claims. Regulators eventually determined that the company had no reinsurance, that assets listed by the company did not exist, and that the bulk of the premium money it collected was not maintained in the company, but rather sent beyond the reach of regulators, much of it into offshore accounts. Unfortunately, risk purchasing groups such as these were not protected by state guarantee funds, given their lack of connection to the licensing state and the provisions of the Federal Act.

Based on the hearing testimony, the Subcommittee, in a July 1992 Report, concluded that, like ERISA’s preemption provisions, the Risk Retention Act is “being utilized by

unscrupulous individuals to defraud the insurance consumer by avoiding current state regulatory authorities.”²⁸

AHP Proposal Would Reinvent MEWA Problems

Our review of all of the above confirmed that time and again, dishonest individuals have exploited federal provisions similar to those now proposed for AHPs to frustrate regulatory efforts for their own personal gain. Time and again, unsuspecting policyholders have been the ultimate victim. The evidence of past abuse strongly suggests that, if enacted, the AHP provisions, with their broad preemption of state regulatory authority, will become an open invitation for fraud, abuse and mismanagement within the health insurance market for small businesses.

Some have argued that the AHP provisions, by granting specific regulatory authority to the Department of Labor and by linking these plans with presumably legitimate associations, will prevent the type of fraud and abuse that plagued MEWAs for so many years. We disagree. In our view, that argument fails to understand the type of fraud and abuse that must be dealt with, the level of sophistication that is involved, and the difficulties that even well-equipped and well-resourced regulators face in this area. As the Director of Insurance for the State of Illinois explained in his testimony at the 1982 House hearings:

[F]or us to expect the U.S. Department of Labor to handle the job that has been given to them under the preemptive language in ERISA is like asking Superintendent Brzeczek here in Chicago to handle the crime problem with three officers and a bicycle. You just can't do it. The task is absolutely overwhelming.”²⁹

The AHP provisions would preempt state regulation and instead provide limited and clearly inadequate regulatory authority to the Department of Labor. The states have spent significant resources and amassed considerable experience in the regulation of insurance over the years. As of 1999, the Department of Labor was already responsible for enforcing ERISA requirements to protect the \$4.3 trillion of retirement assets owed to 90 million participants nationwide by over 700,000 pension plans. In addition, the Department had responsibility for 6 million health and welfare plans.³⁰ In 1997, Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration (PWBA) testified, “My program has 625 people to enforce ERISA requirements for 750,000 pension and 2.5 million health plans. Based on our investigative experience, we could review each pension plan once in 170 years and, if you include health plans, once in 300 years. An infrastructure adequate to handle the new responsibilities [for association plans], replicating the functions of 50 state insurance commissioners, simply does not exist.”³¹

In March of this year, GAO reported on weaknesses in the current enforcement and investigative efforts of the DOL’s Office of Pension and Welfare Benefits Administration (PWBA), which has ERISA enforcement responsibility over employee benefit plans and which would, presumably, assume AHP regulatory authority, should H.R. 2563 be enacted. GAO reported that PWBA, facing an “overabundance of work,” admitted that its enforcement program was already impacted by “limited investigative resources” and “staff shortages.”³² As but one example, PWBA had deferred an effort to determine the level of pension plan noncompliance with ERISA because it concluded that “such an effort would require PWBA’s full investigative staff 90 years to fully and accurately complete.”³³

The AHP provisions would add an open-ended number of health plans and thus expand the breadth and complexity of DOL's and, specifically, PWBA's workload without even adequately correcting the lack of regulatory resources that already exists. The Department of Labor traditionally has not had the authority, the expertise or the experience needed to engage in the business of regulating insurance. As such, the Department has admitted that its enforcement efforts under ERISA are:

...considerably different from and often more limited than the remedies generally available to the states under their insurance laws. In this regard, it is important to note that, in many instances, states may be able to take immediate action with respect to a MEWA upon determining that the MEWA has failed to comply with licensing, contribution or reserve requirements under State insurance laws, whereas investigating and substantiating a fiduciary breach under ERISA may take considerably longer.³⁴

In addition to delays in its own enforcement efforts, the Department has in the past frustrated state regulation of MEWAs by its failure to provide timely advisory opinions on their ERISA status. In the 1990 Senate hearings, state regulators testified that they repeatedly waited many months for responses from the Department to their requests for advisory opinions. Unfortunately, in trying to curb this type of insurance fraud, "time is money." In only a matter of a few months, a fraudulent plan can take in huge amounts in premiums and rapidly divert those monies for private gain, far beyond the reach of any regulator. Unless a regulator is able to move quickly, the effort will come too late, as emphasized in the 1990 testimony of a member of the Texas State Board of Insurance:

...a fraudulent MEWA is a ticking time bomb for consumers. Its promoters do everything they can to slow the process because MEWAs are lucrative "Ponzi" schemes where today's bills and claims are paid with money arriving in tomorrow's mail.

Meanwhile, delays in investigations and the judicial process enable these criminals to recruit more victims and collect more contributions.³⁵

This pattern is not unique to MEWAs and is often seen in all kinds of fraudulent insurance schemes. As mentioned above, it took only 18 months for an insurance company operating under the Risk Retention Act to take in \$16 million in premiums, divert the great bulk of the money beyond the reach of insureds and regulators, and leave \$20 million in unpaid claims. Simply put, the Department of Labor has not demonstrated the kind of timely and effective response needed to protect insureds in these kind of circumstances.

Our review also confirmed that there is no reason to believe that the limited grant of federal authority contained in the AHP provisions will transform the Department into an effective insurance regulator in the future. The provisions require the Department to “certify” AHPs that meet certain minimal requirements regarding such things as sponsorship, board of trustees, and, for self-insured AHPs, reserves. Unlike AHP legislation previously considered, the Secretary is no longer required to determine whether certification would be “protective of the rights and benefits of the individuals covered under the plan.” The provisions require a “filing fee” from each plan which, “to the extent provided in appropriation Acts” is apparently the sole source of additional funding for all the development, operating, investigative and enforcement costs associated with establishing a certification procedure for a still undetermined number of plans.

Compounding the resource problems, the AHP provisions give the Department inadequate tools with which to certify and regulate a greatly expanded universe of health plans. While there are minimum surplus and reserve standard requirements, they only apply to self-

insured, but not fully insured, AHPs, and the amounts are below what is usually required by state regulators. The surplus requirement can be as low as \$500,000 and no greater than \$2,000,000 (regardless of the size of the plan). In a recent letter to Congress, the American Academy of Actuaries stated that this surplus requirement would only be adequate for an AHP with 5,000 to 10,000 participants.³⁶ Insurance regulators have testified that state requirements for these kinds of plans are more typically around \$5 million.³⁷ The provisions do not include a risk-based capital formula, which gives consumers greater protection by considering business, investment and other risks in setting net worth requirements. Specific reserve requirements are set not by an independent, objective regulator, but rather by an actuary hired by the plan itself. While the analogy to recent concerns about independence in accounting and accuracy in corporate financial reporting is an obvious one, H.R. 2563 ignores it and requires no independent verification of the actuarial opinion or the plan information on which it is based.

The provisions require that the plans have only a three year “plan of operation,” but not, as often required by state regulators, pre-funding of losses and planning for the time required to reach the critical “break even point.” The provisions do not provide for any continual oversight of the plan by outside regulators: the Department of Labor is not directed to conduct regular financial and other examinations or to obtain, review, and verify plan financial records and other relevant information. A plan is not required to report problems to the Department until up to 90 days after their discovery, increasing the likelihood that it may be too late for effective regulatory action. Finally, the provisions give the Department no means of intervening to correct solvency issues short of seeking court orders, which connote termination and could involve considerable litigation. By contrast, state regulators often catch financial problems early because of their local presence and early warning systems. States have access to a number of less drastic and more

targeted measures to help correct problems and protect consumers long before the point where termination becomes the only alternative.³⁸

Some have suggested that these limited regulatory powers are adequate since AHPs will be certified only if they meet specified criteria, including sponsorship by a bona fide association. History does not support that argument. The mere presence of bona-fide associations as sponsors does not prevent consumer victimization. Consumers may suffer not only at the hands of fraudulent or sham insurance operations but also as a result of those plans whose proponents are well-intended but lack the experience, skills, and resources to avoid insolvency and succeed in the extremely complex business of insurance. In both types of situations, regular monitoring by state regulators is the consumer's best "insurance" against disaster. As mentioned above, consumers enrolled in plans that could have qualified as AHPs under this legislation comprised a significant share of those that suffered in the past as a result of the previous exemption from state regulation.

The use of association names and sponsorship, as demonstrated in the examples cited previously, can be exploited by fraudulent or poorly managed and inexperienced plans to gain marketing advantage. While consumers may rely on the association's name as proof that the plan itself is legitimate, there is no guarantee that the association has the ability or the will to assure the viability of the health plan. Moreover, the extent to which associations or any insurance consumer is an adequately "informed consumer" often turns on information secured and ultimately provided by state insurance regulators. The AHP provisions eliminate that source of assistance. Small businesses and employees who rely on them, will be forced to proceed at their own risk to determine the likelihood of future mismanagement, insolvency, fraud and abuse

in a given plan. In an area as complex and problematic as insurance and reinsurance, that can be a monumental and extremely perilous task.³⁹

Conclusion

Based on all of the above, we believe that the provisions exempting Association Health Plans from state insurance regulation ignore the critical lessons that should be learned from past experience with fraud and abuse in the insurance industry. Our review of past cases confirmed that fraudulent insurance schemes can and do proliferate at the first suggestion that effective regulation, and the oversight it provides, is lacking. History shows us the speed at which a plan can amass and divert huge amounts of premium dollars. History also warns us of the human tragedy that is all too often left behind.

In short, the lessons of the past dictate the need for caution in an area known to be fraught with peril. The AHP provisions would remove the broad protection afforded by experienced state regulators and create instead a limited, untested, and inexperienced Federal certification effort. The provisions would quickly erase much of the progress that has, at great cost, been made over the years in eliminating loopholes and strengthening the oversight mechanism. As a result, we believe that consumers could once again find themselves largely unprotected and victimized by the type of widespread fraud and abuse that existed prior to the enactment of the Erlenborn-Burton amendment and DOL's subsequent attempts to confirm the states' authority to regulate MEWAs, including AHPs.

¹ H.R. 2563, 107th Cong. §425 (2002).

² *Insurance Fraud Rises With Health-Care Costs Low-Cost Policies Leave Thousands With Unpaid Bills*, The Chicago Tribune, February 19, 2002.

³ Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation; at p. 25 <<http://www.dol.gov/dol/pwba/public/pubs/mwguide.pdf>> (visited June 1, 2000).

⁴ Oversight Investigations of Certain Multiple Employer Health Insurance Trusts (METs), Evading State and Federal Regulation: Hearing Before the Subcomm. on Labor-Management Relations of the House Comm. on Education and Labor, 97th Cong. 1 (1982) [hereinafter House Hearings] (introductory remarks of Rep. John Erlenborn).

⁵ Id. at 29 (testimony of Richard Carlson, Assistant Director of Insurance, State of Illinois).

⁶ Id. at 15 (testimony of Joel Ferrin).

⁷ Id.

⁸ Id. at 5 (testimony of Tyrone Fahner, Attorney General, State of Illinois).

⁹ Id.

¹⁰ Id.

¹¹ Id.

¹² Id.

¹³ Id. at 54 (testimony of Frank Damon, Chief Deputy Insurance Commissioner, California Insurance Department).

¹⁴ Fraud and Abuse in Employer Sponsored Health Plans: Hearing Before the Permanent Subcomm. on Investigations of the Senate Comm. on Governmental Affairs, 101st Cong. 3 (1990) [hereinafter Senate Hearings] (statement of Senator Nunn).

¹⁵ Id. at 16 (testimony of James E. Long, Vice President, National Association of Insurance Commissioners and Insurance Commissioner, State of North Carolina).

¹⁶ Id. at 9 (testimony of JoAnn Howard, Member, Texas State Board of Insurance).

¹⁷ Id. at 11-12 (testimony of Tom Gallagher, Commissioner, Florida Department of Insurance).

¹⁸ S. Rep. No. 102-262, at 17-18 (1992).

¹⁹ U.S. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*, GAO-HRD-92-40, at 2 (March 10 1992).

²⁰ Employer Provided Health Care Coverage: Hearings on H.R. 448 Before the Subcomm. on Employer-Employee Relations of the House Comm. on Education and the Workforce, 106th Cong. [hereinafter House Hearings II] (1999) (testimony of Steven B. Larsen, Commissioner of Insurance, State of Maryland).

²¹ News Releases: Montemayor Warns of Fraudulent Health Plans March 15, 2002; <<http://www.tdi.state.tx.us/commish/nr03272a.html>> (visited March 21, 2002).

²² Id.; News Releases: Another Health Plan Ordered Shut Down March 27, 2002 <<http://www.tdi.state.tx.us/commish/nr03272a.html>> (visited April 14, 2002).

²³ *Labor Secretary Chao Notes Upswing In MEWA Fraud, Vows Response by DOL*, BNA's Health Care Daily Report, February 28, 2002.

²⁴ Senate Hearings, 377.

²⁵ As noted above, the AHP provisions include this same kind of limitation, i.e., the Secretary of Labor will consult with only one state regarding an AHP. Moreover, once a single state approves a filing by a certified AHP, the provisions preclude any other state from regulating the AHP's operations in other states.

²⁶ Efforts to Combat Fraud and Abuse in the Insurance Industry: Hearing Before the Permanent Subcomm. on Investigations of the Senate Comm. on Governmental Affairs, 102d Cong. 22-24 [hereinafter Senate Hearings II] (1991) (testimony of Tim Ryles, Georgia Commissioner of Insurance).

²⁷ E.g., *id.* at 47-49 (testimony of Jim Kelly, Quarterback, Buffalo Bills); *id.* at (testimony of Roynell Young, Founder, Pro Vision Ministries, Former Cornerback, Philadelphia Eagles); *id.* at 52-57 (testimony of Kenneth C. Flowers, Former Runningback, Atlanta Falcons).

²⁸ S. Rep. No. 102-310, at 28.

²⁹ House Hearings, 25 (testimony of Philip R. O'Connor).

³⁰ Fact Sheet September 1999: ERISA's Anniversary - 25 Years of Commitment to Employee Pension and Health Pension and Health Benefits; <<http://www.dol.gov/dol/pwba/public/pubs/factsht1.htm>> (visited March 22, 2002).

³¹ Hearings Before the Senate Labor and Human Resources Committee (October 1, 1997) (statement of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration).

³² U.S. General Accounting Office, *Pension and Welfare Benefits Administration Opportunities Exist for Improving Management of the Enforcement Program*, GAO-02-232, at 19, 20, and 24 (March 15, 2002).

³³ *Id.*, at 18.

³⁴ Multiple Employer Welfare Arrangements Under ERISA p. 17-18, *supra*, note 3.

³⁵ Senate Hearings, 10 (testimony of Jo Ann Howard, Member, Texas State Board of Insurance).

³⁶ Letter to Honorable J. Dennis Hastert, Speaker of the House from John J. Schubert, ASA, FCA, MAAA, Chair, Association Health Plan Work Group, American Academy of Actuaries (April 9, 2002).

³⁷ House Hearings II(statement of Steven B. Larsen, Commissioner of Insurance State of Maryland).

³⁸ Under state law, there are often four levels of state regulatory intervention. The first, “company action level,” is triggered when a health plan’s risk-based capital falls below 200% of its required minimum. At this level, the plan must create and submit a plan of correction. The next step is the “regulatory action level,” which is met when a plan’s risk-based capital falls below 150% of the required minimum. At this level, the state department of insurance must draw up a corrective plan. If a plan falls below 100% of its required minimum, the plan will not be allowed to take any action without approval by the state regulator (“the authority control level”). Finally, a plan reaches “mandatory control level” if it falls below 70% of the required minimum. At this final level only, the state commences insolvency proceedings. Id.

³⁹ I.e., in two of the cases described previously, victims of the fraud and abuse included bar associations and a major insurance company, acting as the claims administrator. Even insurance professionals and attorneys can become unwitting victims, due to the scope, complexity, and outright fraud that characterize many of these schemes.