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Introductory Remarks

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

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

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

Vulnerability of Small Business to Insurance Fraud

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

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

[1] "Study of Administrative Costs and Actuarial Values of Small Health Plans," Actuarial Research Corporation for the U.S. Small Business Administration, January 2003.
[2] Kaiser Family Foundation and Health Research and Education Trust, "Employer Health Benefits, 2003 Annual Survey."
[3] U.S. Agency for Healthcare Research and Quality, based on the Medical Expenditure Panel Survey, Insurance Component, 2001.

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

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

[4] Estimated for EBSA by Actuarial Research Associates, based on the Census Bureau's annual March Current Population Survey and other data.
[5] U.S. General Accounting Office, Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage, GAO-02-8; and Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market, GAO-02-536R.
[6] Williams, Claudia and Jason Lee (2003, September). **Are Health Insurance Premiums Higher for Small Firms**, *The Synthesis Project – Policy Brief Number 2*, Robert Wood Johnson Foundation, 4 pp.
[7] Kaiser Family Foundation and Health Research and Education Trust, "Employer Health Benefits, 2003 Annual Survey."

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

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

ERISA and the Regulatory Environment

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

[8] 29 U.S.C. § 1001, et. seq.; Section 2 of ERISA.
[9] Estimated for EBSA by Actuarial Research Corporation.

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

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

[10] 29 U.S.C. 1144(b)(2)(A); Section 514 (b)(2)(A) of ERISA.
[11] 29 U.S.C. 1144(b)(2)(B); Section 514 (b)(2)(B) of ERISA.

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

How DOL Combats Health Insurance Scams

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

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

DOL/EBSA Prevention Efforts

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

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

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

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

Identifying and Shutting Down Insurance Scams

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

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

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

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

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

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

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

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

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

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

Recent Cases

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

Civil Cases

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

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

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

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

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

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

Criminal Cases

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

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

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

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

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

Going Forward: EBSA Strategy and Resources

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

AHPs – A Quality Alternative to Health Insurance Scams

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

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

Ensuring That AHPs Keep Their Promises

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

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

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

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

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

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

Conclusion

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