**TESTIMONY BEFORE THE**
**UNITED STATES SENATE**
**COMMITTEE ON FINANCE**

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**MARCH 3, 2004**

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Good morning Mr. Chairman and members of the Committee. I am pleased to have this opportunity to discuss with you the very serious problems that health insurance scams pose in Texas and across the country. My name is José Montemayor, and I have held the position of Commissioner of Insurance for the State of Texas since 1999. I am here today seeking your assistance to put a stop to a growing and dangerous problem, unauthorized insurance scams. My department faces a constant onslaught of phony ERISA plans, and my staff receives phone calls and inquiries daily, almost always asking us the same question - who is going to pay the claims left behind by these phony, defunct health plans? Unfortunately, we usually don't have an answer for these questions. Frankly, we're tired of that, and we are seeking your assistance to put a stop to this.

I want to stress from the outset that the current problem is not that the states cannot stop illegal ERISA plans from operating in their jurisdictions. It is that the shield of a potential exemption from state regulation under ERISA currently creates the opportunity for scams to operate for significant periods of time before they are recognized as illegal and before formal action can be taken against them. In Texas, we have the authority to shut down these scams, and we do stop them, but we normally cannot do so until after they have already done a great deal of damage to the public. In Texas, we have issued cease and desist orders against these plans, ordered millions of dollars in penalties against the operators, and we have taken action against those who have sold the plans. In 2003, for instance, I issued over 100 orders against licensed insurance agents who sold unauthorized insurance, ordering them to pay the unpaid

claims – but the salesmen often do not have the money to pay all of the claims. A number of them have declared bankruptcy.

I also want you to know that this problem is not just a matter of a few people being out of some money or a few doctors not getting paid. When these phony plans go under, we get calls from people who are placed in truly desperate circumstances. Here are a few examples. My staff got a call one day from a pregnant woman, due to deliver soon, whose doctors wouldn't see her any more because her insurance, provided to her by her employer, was fake. Kathy Mahan is a specific victim who comes to my mind. She lives in Houston, Texas. She tells us that when she arrived at the hospital for surgery to remove a tumor in her brain, she was told that her surgery had been cancelled because of questions about her health insurance. Though she eventually got the operation, the delay had a negative impact on her health, and now her doctors will not see her for the necessary follow-up treatments because their bills have not been paid. Even worse, Mrs. Mahan's husband, Gerard, also had an operation during this same time period, and his bills have also not been paid, and his doctors won't see him any more. People like this are often forced into bankruptcy through no fault of their own. In many cases, the small business employers who provided them this insurance are also forced out of business when they become liable for the claims of their employees.

Almost every unauthorized plan is a variation on a common theme – a claim of federal exemption from state regulation under the ERISA act. While I certainly recognize ERISA's value to businesses that can afford to self-fund their insurance, almost every illegal health insurance plan we have dealt with began with someone

putting together a set of glossy plan documents which contained some statement, however flimsy, that the plan wasn't regulated by the states. Most of these scams have common elements and run the same course, but they are usually doomed from the beginning. They are usually run by people who are experienced in the industry, often by people who have been involved in prior phony ERISA plans that failed. They try to get as many enrollees as possible, as fast as possible, through low rates and little underwriting, skim as much money off as fast as they can, and then walk away. These people know that they are going to leave unpaid claims, and the more successful they are at marketing the plan on the front end, the more unpaid claims there will be. And these scam artists know that people can die because of their actions.

The biggest unauthorized plan in recent years, Employers Mutual, with 7200 Texas residents enrolled, was perhaps the boldest in this regard. The creators of that plan simply asserted ERISA status with no attempt to explain why. They enrolled virtually anyone who applied. One of their only underwriting guidelines was a request that sales not be made to people already in the hospital. We have now received almost 500 complaints against that company.

Perhaps the second biggest unauthorized plan nationally, American Benefit Plans, at least made up something to support its claimed exemption. It asserted that employers could band together to form what were called "Voluntary Employees Beneficiary Association" or "VEBA" trusts that would be tax-exempt under Section 501(c)(9) of the Internal Revenue Code. From that, they went on to boldly, and falsely, argue that the plan would be exempt from state insurance regulation through the interplay of the tax code and ERISA. Of course, there was no legal basis for such an

argument. Because that plan was based in Texas and we were able to locate many of its assets, we went to court and took it over. We are now sorting out the mess that it left behind.

Probably the third biggest unauthorized plan, known as TRG, had yet another false theory for ERISA exemption – they asserted that anyone could purchase the TRG insurance by becoming nominal employees of TRG and then participating in TRG's own purported "single employer" health plan, exempt from state insurance laws. TRG never paid anyone for their employment, and enrollees did not have to actually do any work for TRG (aside from signing their insurance application).

Another plan, Privilege Care, had a two-part basis for its alleged exemption. It falsely asserted that it could, as a staff leasing company, act as a single employer under ERISA for the groups that signed up under it, but then it did not even obtain a staff leasing license, and it failed to actually operate as a true staff leasing company. It also asserted that it had negotiated a collective bargaining agreement with a union - the Professional and Industrial Trade Workers Union. However, it turned out that none of the people receiving insurance benefits had any idea that they had been unionized. We've gotten almost 200 complaints on that plan so far.

In each of these cases, the perpetrators needed only the barest argument for exemption from state licensing requirements in order to start enrolling mass numbers of people who thought they were getting a great deal on health insurance. Many state departments of insurance were unaware of these plans until the complaints started coming in, and even then it took time to prove that the plans were operating as non-exempt multiple employer plans rather than as exempt single employer plans. Further,

the Department of Labor generally took the position that such plans had some element of ERISA status, and it was certainly not in a position, when consumers called, to quickly opine on whether the plans were subject to state regulation. As with typical ponzi schemes, as long as the numbers were quickly increasing, these plans could continue to pay claims. The plans then started stonewalling on the larger claims as long as they could before either getting shut down by regulators or simply walking away.

With these issues in mind, I would like to take this opportunity to point out some items that I would like the Committee to consider that I believe would be helpful in remedying the problem.

I would request that the Committee consider expanding the powers of the Department of Labor to take action against illegal ERISA plans. Currently, it appears that the DOL must generally prove a breach of fiduciary duty or fraud in order to take civil or criminal action against an ERISA plan or its operators. This is a far cry from the resources the states have in regulating the rest of the insurance industry. In Texas, we take over insurers when we can merely show that the insurer is either insolvent or hazardous to the public. Because it is so much easier to demonstrate that a plan is insolvent than it is to demonstrate that fiduciary duties have been breached, the DOL should be given similar authority to take over ERISA plans. It should always be remembered that ERISA health plans have no statutory requirements to maintain reserves to pay their claims and that there are no guaranty fund protections for the participants enrolled in self-funded ERISA plans, making it even more important that federal regulators be able to take quick action to either rehabilitate or stop plans that are in financial trouble.

The DOL should also be given the authority to issue preliminary cease and desist orders against plans that are in financially hazardous positions or are otherwise violating federal law, at least to the extent of being able to prevent such plans from continuing to enroll new victims.

Also, I would point out that, though the Department of Labor shares regulatory authority over MEWAs with the states, there does not appear to be any specific federal criminal or civil penalty for falsely representing a plan to be exempt from state regulatory authority. There are penalties for impersonating a lawyer or a doctor. Why should a scam artist be able to represent to the unsuspecting public that his plan is exempt from state regulation when it is not. I believe that these perpetrators need additional deterrence from making such misrepresentations.

As I mentioned previously, one of the factors that allows the quick growth of unauthorized plans is the inability of employers and consumers to check on the legality of the plans in which they are being enrolled. In Texas, it is a simple process to check our website or to call our 1-800 telephone line to confirm the licensure of an insurance company or agent. There is nothing similar in the ERISA context. In fact, most ERISA plans are not required to file any documentation regarding their plans or even their existence, until they file their Form 5500s, seven months after the end of their first plan year. Even plans that admit they are MEWAs (which most scams do not) are not required to file their MEWA reporting forms until three months after they make their first sales. This allows many fraudulent operators to truthfully tell consumers that there is no agency to call to check on the legality of the plan and that they are not required to have anything on file with any regulatory authority. Why should ERISA plans, in whom so

many are placing their money and their trust, not be required to make some kind of initial filing in order to put the Department of Labor, and inquiring state regulators, on notice that they are in existence? I recommend that ERISA plans be required to make such a preliminary filing, disclosing, for instance, who will be operating the plan, who will be insured by the plan, and what backing insurance the plan will have.

Related to this are the means that are available to the states to investigate MEWAs. Currently, the purported ERISA plans that we are investigating to determine MEWA status often refuse to provide us any information on the basis that even the authority to investigate whether we have jurisdiction over a plan is pre-empted by ERISA. The states must be given explicit authority to subpoena jurisdictional information from ERISA plans. Additionally, while there is currently a very good system for informally sharing information and documents between state and federal investigators, this tends to break down when it comes time to formally use that information or documentation at state hearings. Often Department of Labor investigators are limited in their ability to testify in state proceedings against MEWAs because of privacy or criminal investigative concerns. I believe that a provision explicitly permitting such investigators to testify and produce documents in state proceedings would greatly increase the speed and effectiveness of our state proceedings in shutting down unauthorized plans.

Another issue that has been presented in a number of cases is the argument that ERISA plans can obtain backing in the form of stop loss insurance from any company they want and in whatever form they want, and the states cannot regulate that insurance in any way because it is “reinsurance” between two “insurers.” The

perpetrators falsely assert, for instance, that they may purchase the equivalent of first-dollar health insurance coverage from unlicensed insurance companies without their plan being considered a MEWA and without the states being able to regulate the so-called “reinsurer” in any way. I recommend clarifying that states are not pre-empted from regulating the insurance purchased by ERISA plans.

Again, I appreciate the Committee allowing me to appear today to discuss these very important issues. I would be happy to answer any questions the Committee might have.