

February 2004

PRIVATE HEALTH INSURANCE

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



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Highlights

Highlights of [GAO-04-312](#), a report to congressional requesters

Why GAO Did This Study

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

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

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

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

PRIVATE HEALTH INSURANCE

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

What GAO Found

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

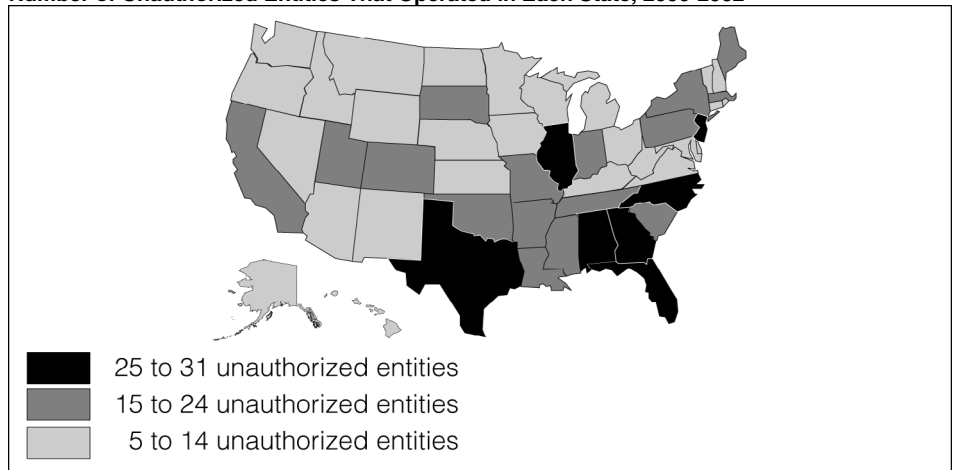
DOL and the states reported that the 144 unique entities

- sold coverage to at least 15,000 employers, including many small employers;
- covered more than 200,000 policyholders; and
- left at least \$252 million in unpaid medical claims, only about 21 percent of which had been recovered at the time of GAO's 2003 survey.

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

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

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



Source: GAO analysis of DOL and state data.

Note: Some of the unauthorized entities operated in more than one state so the total number of entities identified by DOL and the states exceeds the total of 144 unique entities.

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Abbreviations

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

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

February 27, 2004

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

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

The Honorable Christopher S. Bond
United States Senate

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

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

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

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

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

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

²Throughout this report, we include the District of Columbia in our discussion of states; we refer to each state's insurance department, division, or office as an insurance department.

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

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

Results in Brief

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

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

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

DOL and the states reported that the 144 unauthorized entities covered at least 15,000 employers and more than 200,000 policyholders from 2000 through 2002. The states reported that more than half of the entities they identified frequently targeted their health benefits to small employers. At the time of our 2003 survey, DOL and the states reported that the identified entities did not pay at least \$252 million in medical claims and only about \$52 million—about 21 percent of the total unpaid claims—had been recovered on behalf of policyholders and those covered by the policies. Ten of the 144 entities covered about 64 percent of the affected employers and about 56 percent of the policyholders, and accounted for 46 percent of the unpaid claims.

States and DOL employed similar methods to identify these unauthorized entities and to prevent them from operating, but used different methods to stop their activities. To identify these entities, state insurance departments and DOL often relied on consumer complaints. The primary action states took to stop the entities' activities was to issue cease and desist orders. State insurance departments issued these orders against 41 of the 144 unique entities identified from 2000 through 2002. Such an order, however, only applies to the activity in the issuing state. DOL relied on the states to issue cease and desist orders while it conducted investigations to obtain evidence that it could use to stop these entities in multiple states through the federal courts. DOL obtained court orders against three entities from

2000 through 2002. Each of these three entities affected consumers in more than 40 states; combined, the three entities affected an estimated 25,000 policyholders and accounted for about \$39 million in unpaid claims. Because most of the DOL investigations were ongoing as of August 2003, further actions remain possible. States and DOL primarily focused their prevention efforts on improving public awareness, including the need for consumers, employers, and insurance agents to verify an entity's legitimacy with insurance departments.

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

Background

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

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

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

States regulate the insurance products that many employers purchase.⁶ Each state's insurance department enforces the state's insurance statutes and rules. Among the functions state insurance departments typically perform are licensing insurance companies, managed care plans, and agents who sell these products; regulating insurers' financial operations to ensure that funds are adequate to pay policyholders' claims; reviewing premium rates; reviewing and approving policies and marketing materials to ensure that they are not vague and misleading; and implementing consumer protections such as those relating to appeals of denied claims.⁷

The federal government regulates most private employer-sponsored pension and welfare benefit plans (including health benefit plans) as required by the Employee Retirement Income Security Act of 1974 (ERISA).⁸ These plans include those provided by an employer, an employee organization (such as a union), or multiple employers through a multiple employer welfare arrangement (MEWA).⁹ DOL is primarily responsible for administering Title I of ERISA. Among other requirements, ERISA establishes plan reporting and disclosure requirements and sets

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

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

⁷State insurance regulators established NAIC to help promote effective insurance regulation, to encourage uniformity in approaches to regulation, and to help coordinate states' activities. Among other things, NAIC develops model laws and regulations to assist states in formulating their policies to regulate insurance.

⁸Pub. L. No. 93-406, 88 Stat. 829.

⁹MEWAs, which can be insured or self-funded, are plans or other arrangements that provide health and welfare benefits to the employees of two or more employers. Under ERISA, MEWAs do not include certain plans that the Secretary of Labor finds are the result of collective bargaining agreements, or plans established or maintained by a rural electric cooperative or a rural telephone cooperative association.

fiduciary standards for the persons who manage and administer the plans.¹⁰ These requirements generally apply to all ERISA-covered employer-sponsored health plans, but certain requirements vary depending on the size of the employer or whether the coverage is through an insurance policy or a self-funded plan. In addition, ERISA generally preempts states from directly regulating employer-sponsored health plans (while maintaining states' ability to regulate insurers and insurance policies). Therefore, under ERISA, self-funded employer group health plans generally are not subject to the state oversight that applies to the insurance companies and health insurance policies. Prior to 1983, a number of states attempted to subject MEWAs to state insurance law requirements, but MEWA sponsors often claimed ERISA-plan status and federal preemption. A 1983 amendment to ERISA made it clear that health and welfare benefits provided through MEWAs were subject to both federal and state oversight.¹¹ The federal and state governments now coordinate the regulation of MEWAs, with states having the primary responsibility to regulate the fiscal soundness of MEWAs and to license their operators and DOL enforcing ERISA's requirements.

DOL and States Identified 144 Unique Unauthorized Entities Operating from 2000 through 2002

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

¹⁰Under ERISA, a fiduciary generally is any person who exercises discretionary authority or control respecting the management or administration of an employee benefit plan or the management or disposition of the plan's assets.

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

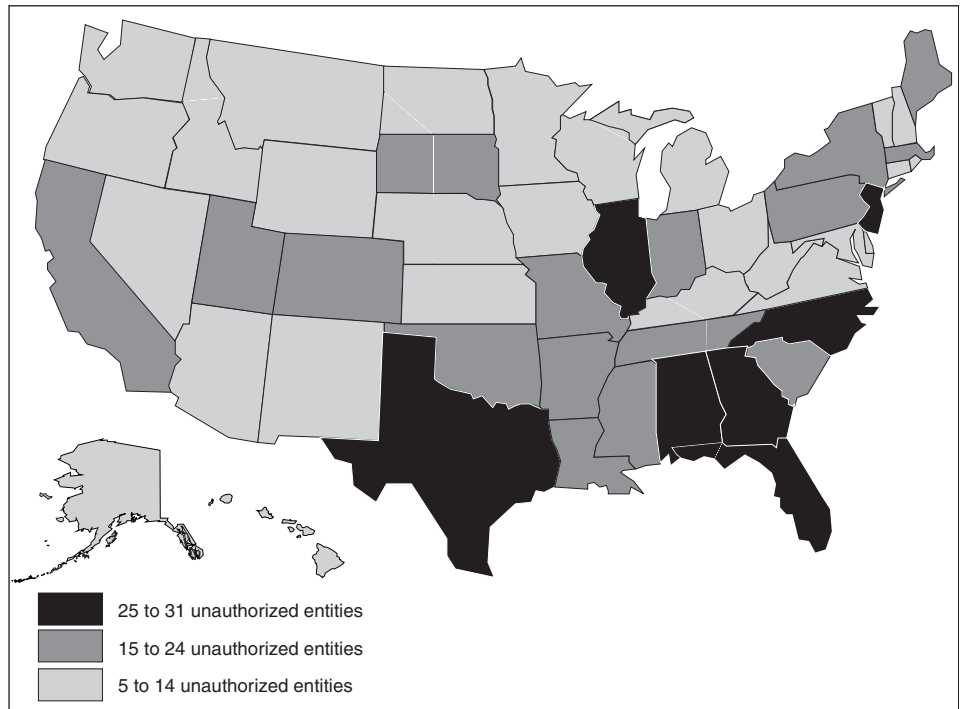
Unauthorized Entities Were Concentrated in the South and the Number Identified Grew Rapidly from 2000 through 2002

DOL and 42 states¹² identified 144 unique unauthorized entities from 2000 through 2002. Many of these entities marketed their products in more than one state, and some operated under more than one name or with more than one affiliated entity. This likely represents the minimum number of unauthorized entities operating from 2000 through 2002 because some states did not report on entities that they were still investigating. Of the 144 unique entities, the states identified 77 entities that DOL did not, DOL identified 40 that the states did not, and both the states and DOL identified another 27.

Unauthorized entities identified by DOL and the states from 2000 through 2002 operated in every state, ranging from 5 entities in Delaware and Vermont to 31 in Texas. (See fig. 1.) Some of the unauthorized entities operated in more than one state so the total number of entities identified by DOL and the states exceeds the total of 144 unique entities. Unauthorized entities were concentrated in certain states and regions. Seven states had 25 or more entities that operated during this period; 5 of these states were located in the South. In addition to the 31 entities in Texas, there were 30 in Florida, 29 each in Illinois and North Carolina, 28 in New Jersey, 27 in Alabama, and 25 in Georgia.

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

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

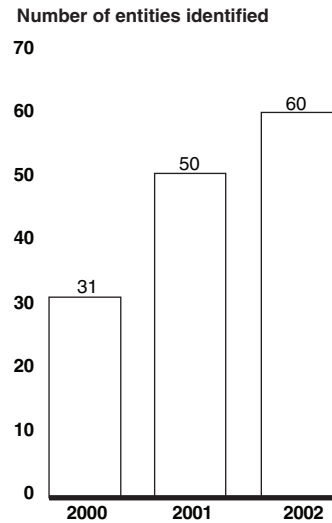


Source: GAO analysis of DOL and state data.

Note: Some of the unauthorized entities operated in more than one state so the total number of entities identified by DOL and the states exceeds the total of 144 unique entities.

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

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



Source: GAO analysis of DOL and state data.

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

Several DOL officials, state officials, and experts pointed to rapidly increasing health care costs and the weak economy as two factors contributing to the recent growth in the number of identified unauthorized entities. They suggested that the pressure of rising premiums and decreasing revenues may have increased employers' demand for more affordable employee health benefits, particularly among small employers, and thereby created an environment where unauthorized entities could spread. From 2000 through 2002, firms with fewer than 50 workers experienced an average annual increase in their workers' health benefits of about 13.3 percent, whereas firms with 50 or more workers experienced an average annual increase of 10.9 percent.¹³ The United States economy also showed signs of weakness in the third quarter of 2000 when it experienced growth of 0.6 percent, and suffered a recession in 2001. The economy's subsequent recovery in 2002 was marked by moderate economic growth but rising unemployment. Negative or weak growth in employers' revenues,

¹³We based our calculation on data reported in Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2000 Annual Survey*, *Employer Health Benefits 2001 Annual Survey*, and *Employer Health Benefits 2002 Annual Survey* (Menlo Park, Calif. and Chicago: 2000, 2001, and 2002).

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

Entities Characterized Themselves as One of Several Common Types of Arrangements

About 80 percent of the unauthorized entities identified by DOL and the states characterized themselves as associations, professional employer organizations, unions, single-employer ERISA plans, or some combination of these arrangements. The operators of these entities often characterized the entities as one of these common types to give the appearance of being exempt from state regulation, but often states found that they actually were subject to state regulation as insurance arrangements or MEWAs. Under ERISA, both states and the federal government regulate MEWAs, with states focusing on regulating the fiscal soundness of MEWAs and licensing their operators and DOL enforcing ERISA's requirements.

Specifically, as shown in table 1, 27 percent of the entities identified by the states and DOL characterized themselves as associations in which employers or individuals bought health benefits through existing associations, or through newly created associations established by the unauthorized entities. For example, Employers Mutual, LLC, an entity that operated in 2001, sold coverage through an existing association. Employers Mutual also created 16 associations as vehicles for selling its products. (See app. II for a more detailed discussion of Employers Mutual, LLC.) In addition, 26 percent of the entities identified were professional employer organizations, also known as employee leasing firms, which contracted with employers to administer employee benefits and perform other administrative services for contract employees. Another 9 percent of the entities identified claimed to be union arrangements that would be exempt from state regulation. However, they lacked legitimate collective bargaining agreements and were therefore subject to state oversight. Eight percent of the entities identified characterized themselves as single-employer ERISA plans and claimed to be administering a self-funded plan for a single employer. Such plans, when administered with funds from one employer for the benefit of that employer's workers, are exempt from state insurance regulation under ERISA. However, assets for several employers were commingled in these entities, making them MEWAs subject to state regulation.

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

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

Source: GAO survey of states and DOL data.

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

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

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

Some States Reported That Discount Plans Misrepresented Themselves as Health Insurance

Some discount plans, in which the purchaser receives a discount from the full cost of certain health care services from participating providers, were misrepresented as insurance. Unlike legitimate insurance, discount plans do not assume any financial risk nor do they pay any health care claims. Instead, for a fee they provide a list of health care providers that have agreed to provide their services at a discounted rate to participants. In response to our survey, 40 states reported that they were aware that discount plans were marketed in their state, and 14 states reported that some discount plans were inappropriately marketed as health insurance products in some manner. Among these 14 states, 8 reported that the inappropriately marketed discount plans targeted small employers. While discount plans are not problematic as long as purchasers clearly understand the plans, these 14 states reported that some discount plans were marketed as health insurance with terms or phrases such as “medical plan,” “health benefits,” or “pre-existing conditions immediately accepted.” (See app. III for more information on discount plans.)

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

At least 15,000 employers, including many small employers, purchased coverage from unauthorized entities, affecting more than 200,000 policyholders from 2000 through 2002. The states reported that more than half of the organizations they identified frequently targeted their health benefits to small employers. At the time of our 2003 survey, DOL and states reported that the 144 entities had not paid at least \$252 million in medical claims, and only about 21 percent of these claims, about \$52 million, had been recovered on behalf of those covered by these entities. Ten of the 144 entities covered the majority of employers and policyholders and accounted for almost one half of unpaid claims.

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

At the time of our 2003 survey, DOL and state officials reported that unauthorized entities had not paid at least \$252 million in medical claims. This represents the minimum amount of unpaid claims associated with these entities identified from 2000 through 2002 because in some cases DOL and the states did not have complete information on unpaid claims for the entities they reported to us.

Federal and state governments reported that about 21 percent of unpaid claims had been recovered from entities identified from 2000 through 2002—\$52 million of \$252 million.¹⁵ These recoveries could include assets seized from unauthorized entities that had been shut down or frozen from other uses. Licensed insurance agents have also settled unpaid claims voluntarily or through state or court action. However, the amount of unpaid claims recovered could grow over time as ongoing investigations are resolved. Investigations of unauthorized entities are complex and require

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

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

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

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

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

Dollars in millions

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

Source: GAO analysis of DOL and state data.

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

^aDOL data were as of June 2003 and most state data were reported from March through June 2003.

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

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

States and DOL Relied on Similar Methods to Identify Unauthorized Entities

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

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

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

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

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

Source: GAO analysis of state survey responses.

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

^a“Other” includes identification through an insurance company, contact with another state, and other methods.

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

DOL Identified Entities through Consumer and State Contacts

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

Federal investigators also relied on states to help identify unauthorized entities. An EBSA headquarters official told us that states usually alerted federal investigators to the entities operating within their regions. The directors of the three EBSA regional offices we interviewed said they had received referrals from state insurance department officials within their regions.

State Insurance Departments Issued Cease and Desist Orders to Stop Unauthorized Entities, While DOL Took Action through the Federal Courts

States generally issued cease and desist orders to stop the activities of unauthorized entities. In contrast, DOL obtained injunctive relief through the federal courts by obtaining temporary restraining orders (TRO) or preliminary or permanent injunctions to stop unauthorized entities' activities. DOL often relied on states to stop unauthorized entities through cease and desist orders while it conducted investigations, usually in multiple states, to obtain the evidence needed to stop these entities' activities nationwide through the courts.

States Issued Cease and Desist Orders to Stop Activities of Unauthorized Entities

After identifying the unauthorized entities, the primary mechanism states used to stop them from continuing to operate was the issuance of cease and desist orders. Generally, these cease and desist orders told the operators of the entities, and affiliated parties, to stop marketing and selling health insurance in that state and in some cases explicitly established their continuing responsibility for the payment of claims and other obligations previously incurred. About 71 percent of the states (30 of 42 states) that reported unauthorized entities operating within their borders from 2000 through 2002 issued at least one cease and desist order to stop an entity's activities during that time. The number of cease and desist orders issued by each of the 30 states ranged from 1 to 11, averaging about 4 per state. Alabama, Illinois, and Texas, three states in which more than 25 unauthorized entities operated, reported issuing the most cease and desist orders. A cease and desist order applies to activities only within the state that issues the order. Therefore, in several cases, more than one state issued a cease and desist order against the same entity. For example, 14 states reported that they each issued a cease and desist order to stop Employers Mutual's operations within their borders. States issued a total of 108 cease and desist orders that affected 41 of the 144 unique entities nationwide. About 58 percent of policyholders and nearly half of unpaid claims were associated with these 41 entities.

State insurance departments generally had the authority to issue cease and desist orders. The insurance department officials we interviewed in Colorado, Florida, Georgia, and Texas said that the insurance

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

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

States took other actions against the entities, sometimes in conjunction with issuing cease and desist orders. For example, in 48 instances states responding to our survey reported that they took actions against or sought relief from the agents who sold the entities' products, including fining them, revoking their licenses, or ordering them to pay outstanding claims.¹⁶ States also reported that they took actions against the entity operators in 25 instances and filed cases in court in 14 instances.

DOL Stopped Unauthorized Entities' Activities through Federal Courts

DOL can take enforcement action to stop an unauthorized entity's activities through the federal courts—that is, by seeking injunctive relief and, in some cases, pursuing civil and criminal penalties. An injunction is an order of a court requiring one to do or refrain from doing specified acts. Injunctive relief sought by DOL against unauthorized entities includes TROs, which may be issued without notice to the affected party and are effective for up to 10 days; preliminary injunctions, which may be issued only with notice to the affected party and the opportunity for a hearing; and permanent injunctions, which are granted after a final determination of the

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

facts. DOL's enforcement actions apply to all states affected by the entity. To obtain a TRO, DOL must offer sufficient evidence to support its claim that an ERISA violation has occurred and that the government will likely prevail on the merits of the case. Documenting that a fiduciary breach took place can be difficult, time-consuming, and labor-intensive because DOL investigators often must work with poor or nonexistent records, uncooperative parties, and multiple trusts and third-party administrators.

As of December 2003, DOL had obtained TROs against three entities for which investigations were opened from 2000 through 2002. In two of these cases, DOL also obtained preliminary injunctions and in one case a permanent injunction. (See table 4.) Each of these actions affected people in at least 41 states. These three entities combined affected an estimated 25,000 policyholders and accounted for about \$39 million in unpaid claims.

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

Unauthorized entity	Number of states affected	TRO issued ^a	Preliminary injunction obtained	Permanent injunction obtained	Other results
Employers Mutual	51	December 2001	February 2002 ^b	September 2003	In September 2003, a federal court ordered the principals to pay about \$7.3 million
OTR Truckers Health and Welfare Fund	44	June 2002	None	None	In September 2002, one defendant agreed to pay an amount that was less than 1 percent of the unpaid claims
Service and Business Workers of America Local 125 Benefit Fund	41	October 2002	October 2002 ^c	None	None

Source: EBSA.

^aGenerally, these TROs froze the unauthorized entity's assets; removed the operators; prevented the operators from managing the entity; and appointed an independent fiduciary to manage the entity, account for assets, and pay claims.

^bPreliminary injunction extended appointment of fiduciary and prevented health care providers from taking action against participants to collect unpaid bills.

^cPreliminary injunction ordered termination of the entity and prevented health care providers from taking action against participants to collect unpaid bills or other actions.

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

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

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

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

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

¹⁷The states also identified 27 of these 69 entities.

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

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

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

States Alerted Consumers and Agents and Benefited from NAIC Efforts

Insurance department officials we interviewed in four states took various actions to prevent unauthorized entities from continuing to operate. Each of these states issued news releases to alert the public about these entities in general and to publicize the enforcement actions they took against specific entities. To help states increase public awareness, NAIC developed a model consumer alert in the fall of 2001, which it distributed to all the states and has available on its Web site. (See app. IV.) The four states' insurance departments also maintained Web sites that allow the public to search for those companies authorized to conduct insurance business within their borders. These states have also taken other actions to increase public awareness. For example, in April 2002, Florida released a public service announcement to television news markets throughout the state to warn about these entities. In addition, in the spring of 2003, Florida placed billboards throughout the state to warn the public through its "Verify Before You Buy" campaign. (See fig. 3.)

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



**Think you're Covered?
Don't go bare**

*Make sure your insurance
company is licensed in Florida*

call 800-342-2762

VERIFY BEFORE YOU BUY

Florida Department of
Financial Services
public service provided by the
Florida Outdoor Advertising
Association

Source: Florida Department of Financial Services.

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

restitution, lost their licenses, or faced a combination of some or all of these actions.

DOL Alerted Employer Groups and Provided Guidance and Assistance to States and Others

DOL primarily focused its efforts to prevent unauthorized entities from continuing to operate on employer groups, small employers, and the states. To help increase public awareness about these entities, on August 6, 2002, the Secretary of Labor notified over 70 business leaders and associations, including the U.S. Chamber of Commerce and the National Federation of Independent Business, about insurance tips that the department had developed and asked them to distribute the tips to small employers. Consistent with the advice states provided, among other things, the tips advised small employers to verify with a state insurance department whether any unfamiliar companies or agents were licensed to sell health benefits coverage. (See app. V.) Also, the three EBSA regional offices we reviewed had initiated various activities within the states in their regions. For example, EBSA's Atlanta regional office sponsored conferences that representatives from 10 states and NAIC attended. Federal and state representatives discussed ERISA-related issues and their investigations at these conferences. Furthermore, since 2000, DOL initiated several technical assistance efforts to help states and others better understand ERISA-related issues. These efforts are intended to help prevent unauthorized entities from avoiding state regulation.²⁰

Agency and Other External Comments

We provided a draft of this report to DOL, NAIC, and the four state insurance departments (Colorado, Florida, Georgia, and Texas) whose officials we interviewed. DOL, NAIC, Florida, and Texas provided written comments on the draft. Colorado and Georgia did not provide comments on the draft.

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

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

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

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


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

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

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

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

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



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

Methodology for Identifying Unauthorized Entities

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

Survey of State Insurance Departments

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

Part I of the survey asked for selected data elements on the entities. We asked the states to use the following definition: "an unauthorized health benefits plan is defined as an entity that sold health benefits, collected premiums, and did not pay or was likely not to pay some or all covered claims. These entities are also known as health insurance scams." First, we asked officials in each state to tell us how many of these entities covering individuals in the state they identified during each of 3 calendar years—2000, 2001, and 2002. For each entity the state identified during the 3-year period, we requested information such as the (1) number of employers covered, (2) number of policyholders covered, (3) total amount of unpaid claims in the state, and (4) amount of unpaid claims recovered. We also obtained information on the type of the entity, how the state identified the entity, and what actions the state took regarding the entity. Part II of the survey collected information on other types of problematic plans—including discount plans—and whether these other types of plans targeted small employers.

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

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

Federal Data on Unauthorized Entity Investigations

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

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

Consolidating State and Federal Data on Unauthorized Entities

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

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

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

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

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

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

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

**Appendix I
Methodology for Identifying Unauthorized
Entities**

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

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

Employers Mutual, LLC and Federal and State Actions

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

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

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

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

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

regulation under the Employee Retirement Income Security Act of 1974 (ERISA).

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

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

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

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

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

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

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

States, Then DOL, Acted against Employers Mutual

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

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

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

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

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

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

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

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

The TRO temporarily froze the assets of all the principals involved in this entity and prohibited them from conducting further activities related to the business. It also appointed an independent fiduciary to administer Employers Mutual and associated entities and, if necessary, implement their orderly termination.

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

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

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

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

recovered by DOL and the independent fiduciary.¹² On September 10, 2003, the court issued a default judgment granting a permanent injunction against the principals and ordered them to pay \$7.3 million in losses suffered as a result of their breach of fiduciary obligations to beneficiaries.¹³

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

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

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

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

**Appendix II
Employers Mutual, LLC and Federal and
State Actions**

Figure 4: Key Events of Employers Mutual from Establishment to Closure

2000	2001	2002	2003
<p>July 28, 2000 Employers Mutual is established in Nevada.</p> <p>December 27, 2000 Principals begin to establish associations that had trust agreements with Employers Mutual.</p>	<p>January - October 2001 Employers Mutual collects approximately \$16 million in premiums from over 22,000 policyholders.</p> <p>January - October 2001 Employers Mutual pays principals' investment firms.</p> <p>May 2001 Principals establish two provider networks.</p> <p>June 14, 2001 Nevada issues cease and desist order against Employers Mutual.</p> <p>August - December 2001 Alabama, Colorado, Florida, Oklahoma, Texas, and Washington take action against Employers Mutual.</p> <p>October 3, 2001 Claims processing firm terminates contract with Employers Mutual.</p> <p>November 21, 2001 Nevada seizes Employers Mutual's assets held in Nevada banks.</p> <p>December 13, 2001 U.S. District Court for the District of Nevada^a grants a temporary restraining order against Employers Mutual and appoints an independent fiduciary.</p> <p>December 20, 2001 Nevada surrenders to independent fiduciary the Employers Mutual assets it seized.</p>	<p>January 2002 U.S. District Court holds hearing.</p> <p>February 1, 2002 U.S. District Court issues preliminary injunction.</p> <p>April 30, 2002 U.S. District Court issues quasi-bankruptcy order.</p>	<p>March 3, 2003 Independent fiduciary files civil complaint against Employers Mutual's principals and insurance agents and brokers that marketed the 16 plans.</p> <p>September 10, 2003 U.S. District Court issues a default judgment granting a permanent injunction against Employers Mutual. Principals ordered to pay \$7.3 million.</p> <p>October 20, 2003 U.S. District Court orders the civil suit to mediation in February 2004.</p>

Source: U.S. District Court, independent fiduciary, and seven states.

Appendix II
Employers Mutual, LLC and Federal and
State Actions

Note: Includes information from the preliminary injunction, the permanent injunction, and cease and desist orders from, Alabama, Colorado, Florida, Nevada, Oklahoma, Texas, and Washington.

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

Discount Plans Have Been Marketed as Health Insurance in Some States

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

Overview of Discount Plans

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

Most state insurance departments do not regulate discount plans because they are not considered to be health insurance. None of the insurance departments in the states that we reviewed—Colorado, Florida, Georgia, and Texas—regulated discount plans. Thus, according to a state official, while state insurance departments might be aware that discount plans operated within their borders, they would not necessarily be able to quantify the extent to which they exist. When consumers complain about discount plans in Colorado, for example, the insurance department refers the complaints to the Attorney General.¹

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

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

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

Discount Plans
Misrepresented in
Some States

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

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

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

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

Source: GAO analysis of data reported by states.

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

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


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

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

Consumer Alert Developed by the National Association of Insurance Commissioners

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

Figure 5: Consumer Alert from NAIC



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

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

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

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

The National Association of Insurance Commissioners is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and four U.S. territories. The overriding objectives of state regulators are to protect consumers and help maintain the financial stability of the insurance industry. If you would like more information or wish to be removed from the "Consumer Alert" media list, please contact the Communications Department at (816) 842.3600 or Communications@naic.org.

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


Department of Labor Memorandum and Insurance Tips for Small Employers

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

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

Figure 6: Insurance Tips for Small Employers

Fact Sheet



U.S. Department of Labor
Employee Benefits Security Administration
October 2003

How to Protect Your Employees When Purchasing Health Insurance

- **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. Promoters of insurance scams often engage unlicensed insurance agents to market their product as a cheaper alternative to traditional insurance. Check out unknown agents with your state insurance department.
- **Verify** that any unfamiliar company, organization or product is approved by your state insurance department.
- **Examine the policy** to determine the actual coverage and whether the promised benefits are fully insured by a licensed insurance company. Do not confuse representations about stop-loss coverage with a guarantee of group health benefits. Stop-loss coverage often protects only the issuer, not the insured individuals.
- **Request references** of employers enrolled with the provider and get information from employers about benefit payment history and claim turn around time.
- **Ask about the allocation of premiums** charged for commissions, fees and administration expenses. Allocation of a high percentage of the premiums to commissions, fees and administrative expenses may indicate a problem with the product or insurer.
- **Contact** your Regional Office of the Employee Benefits Security Administration (U.S. Department of Labor) through its toll-free number at **1-866-444-EBSA (3272)** or at www.askebsa.dol.gov to report problems.

Source: DOL.

Comments from the Department of Labor

U.S. Department of Labor

Assistant Secretary for
Employee Benefits Security Administration
Washington, D.C. 20210



FEB 9 2004

Ms. Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

Thank you for providing the Department of Labor (DOL) with the opportunity to comment on the General Accounting Office's draft report entitled "Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage" (GAO-04-312). I want to take this opportunity to offer a few general comments on the draft report. We have also enclosed a list of technical comments for your consideration.

Initially, I want to bring to your attention and highlight the Department's increased coordination efforts with the States and law enforcement agencies regarding investigative and oversight responsibilities of MEWAs and other entities offering health care coverage. Although your draft report mentions various efforts by the DOL and the States, I think you should be aware of, and the draft report should reflect, some of our increasing coordination efforts. These increased efforts, carried out through the DOL's Employee Benefits Security Administration, include the following:

Coordination with the State Insurance Departments

States and the federal government coordinate the regulation of unauthorized insurance entities (including MEWAs) pursuant to the 1983 amendment to ERISA that made it clear that states are free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan. State insurance laws that set standards requiring specified levels of reserves or contributions are applicable to MEWAs even if they are also covered by ERISA.

The states and EBSA carry out their MEWA coordination activities in a number of ways. For instance, EBSA provides to the National Association of Insurance Commissioners (NAIC), on a quarterly basis, a list of all on-going MEWA investigations identifying geographic coverage and principal players. The NAIC provides EBSA copies of its MEWA Alert, identifying high profile MEWA investigations by state and identifies specific insurance department staff contacts. EBSA has also provided the names and telephone numbers of Regional Office MEWA coordinators who may be contacted to discuss local MEWA issues.

EBSA also is a regular attendee of and participant in the NAIC quarterly meetings, particularly at the regulator-only sessions where specific MEWA investigations are briefed. Over the past five years

Appendix VI
Comments from the Department of Labor

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

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

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

EBSA Criminal Enforcement Efforts Related to MEWAs

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

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

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

Appendix VI
Comments from the Department of Labor

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

Sincerely,



Ann L. Combs
Assistant Secretary
Employee Benefits Security Administration

Enclosure

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