GEORGETOWN UNIVERSITY

Health Policy Institute

Testimony before the

United States Senate
Committee on Finance

On

Health Insurance Challenges: "Buyer Beware."

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March 3, 2004

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Good morning. My name is Mila Kofman and I am an assistant research professor at the Georgetown University's Health Policy Institute (Institute). Thank you for inviting me to testify on the problem of unauthorized health plans. It is both an honor and a privilege to be here.

As a way of background, researchers at the Institute conduct a range of studies on the uninsured problem. My specific focus is private health insurance, state and federal reforms to improve access to health coverage, and cost of insurance. I have extensively studied the problem of phony insurance and last year published a report studying this cycle of scams, how they work, and what states and the federal government are doing to better protect consumers and help victims. This research was funded by the Commonwealth Fund. I respectfully request that the Issue Brief called "Health Insurance Scams: How Government is Responding and What Further Steps are Necessary" published by the Commonwealth Fund summarizing my findings be entered into the record in addition to my testimony.[1] The detailed report was published by BNA.[2]

Before joining the faculty at Georgetown University, I was a federal regulator at the U.S. Department of Labor, where I worked on legislation affecting association health plans in addition to regulating such arrangements and implementing federal reforms affecting ERISA health plans. Prior to joining the U.S. Department of Labor, I was Counsel for Health Policy and Regulation at the Institute for Health Policy Solutions, a non-profit, non-partisan firm, assisting small businesses in establishing health insurance purchasing coalitions. My knowledge, therefore, is both practical and academic.

First, I want to thank you for your leadership in investigating the current cycle of health insurance scams. The private market is experiencing a significant problem — criminals defrauding employers and America's workers and their families out of health insurance premiums. Operators of phony health plans target businesses and self-employed people, collect premiums for non-existent health insurance, and leave patients with millions of dollars in unpaid medical bills and without health insurance. For victims, this is worse than being uninsured. When you are uninsured, at least you haven't paid premiums for the privilege of being uninsured. Here, victims are defrauded of thousands of dollars in premiums and then left with huge medical bills.

There has been a long history of scams, with cycles of increased criminal activity. So first, I will give you a historical perspective, which will help explain some of the reasons why we have this problem today. Then I'll discuss how these schemes work focusing on the common elements among the scams I've studied. Then I'll discuss some of the more effective strategies used by states and the federal government in responding to the current wave of scams. In closing I will offer ideas on how to better protect consumers from health insurance scams.

HISTORICAL PERSPECTIVE

This is not the first time that health insurance scams have defrauded American workers and businesses. In fact, this is the third cycle of scams in the last three decades.

First Cycle of Scams: ERISA, 1974 to 1983

The first wave of scams occurred after the Employee Retirement Income Security Act (ERISA), a law federalizing regulation of employee benefits, was enacted in 1974. The influx of scams was an unintended consequence of ERISA.

As you know, ERISA preempts states from regulating ERISA covered employee benefit plans sponsored by private employers. In addition, the original 1974 ERISA statute (pre 1982 amendments) severely restricted state authority to regulate multiple employer arrangements (e.g., a purchasing coalition of employers) that met the requirements to be considered ERISA plans. In reality, however, most multiple employer arrangements were not ERISA plans. But, that didn't stop unscrupulous operators from claiming ERISA preemption when states tried to regulate such arrangements. At the time, the U.S. Department of Labor claimed not to have authority over such arrangements because most were not ERISA plans. Ambiguity about whether states had authority to regulate and limited oversight by the U.S. Department of Labor created opportunities for widespread fraud.

In response, in 1982 (effective 1983) the U.S. Congress amended ERISA to clarify that states could regulate multiple employer arrangements called MEWAs (multiple employer welfare arrangements) even if such arrangements could meet the requirements of an ERISA plan. The clarification removed an ambiguity of which fraudulent operators had taken advantage. This made it possible for states to take more aggressive actions against phony health plans trying to hide behind the ERISA shield.

Second Cycle of Scams: 1988 to 1991

The second wave of scams coincided with double-digit increases in health insurance premiums. In the late 1980s and early 1990s employers faced double-digit premium increases. During the same time period, documented very well by the U.S. General Accounting Office (GAO), MEWA failures, including scams and insolvencies, had increased. During that time MEWAs left thousands of people without health insurance and nearly 400,000 patients with medical bills exceeding $123 million.[3]

Through the 1990s as premiums were stable, there were fewer arrangements operating illegally. However, questions about states' authority to regulate MEWAs persisted despite Congressional actions in the early 1980s fixing most of the ERISA problem. Operators of scams continued to use ERISA as a shield, taking advantage of some ambiguities created by the amendment. For example, although Congress clarified that states can regulate MEWAs, collectively bargained union plans are not considered MEWAs and therefore not subject to state oversight. Ambiguity over what is a collectively bargained union plan has resulted in promoters of phony coverage selling these plans through phony unions and holding themselves out as exempt from state oversight as collectively bargained union plans.[4] In response to this problem, last year, the U.S. Department of Labor issued a regulation to help clarify whether an arrangement is a collectively

bargained union plan exempt from state insurance oversight.[5] It is too early to tell whether this regulation will prevent promoters of scams from claiming to be a collectively bargained union plan and therefore trying to avoid state oversight.

Third Cycle of Scams: 2000 to unknown

We are in the midst of a third wave of health insurance scams. Since 2000, just four unauthorized entities enrolled over 100,000 people nationwide and left more than $85 million in unpaid medical claims — which of course the victims are now responsible for paying (See Table 1).

Unlike licensed insurance companies, when an unauthorized arrangement becomes insolvent, there is no safety net like a state guaranty fund to pay claims. So after paying premiums and believing that they have insurance, employers and patients are stuck with medical bills. For some victims this means loss of life's savings and homes, destroyed credit, and in some cases bankruptcy.

The current problem with health insurance scams is national in scope. People in every state, including Alaska and Hawaii, have been defrauded. In Florida health insurance scams have left nearly 30,000 people without health insurance and unpaid medical bills. A regulator from Oklahoma reported that in 2002 she had 60 open investigations — more than she's ever had in her 20 some years with the insurance department (see Table 2 for a summary of state activities between 2000-2002). Louisiana established an emergency team to find and shut down scams. Other insurance departments shifted staff to investigate and shut down scams.

The recent wave of health insurance scams, consistent with history, can be attributed to greater demand for affordable health insurance in the face of double-digit increases in premiums. Employers and individuals who are desperate to find affordable coverage are at risk of being conned by scams.

HOW SCAMS WORK

Research Methodology

This research, funded by the Commonwealth Fund, on the magnitude of this current scam problem also looked at state and federal strategies that seem to be working in combating this problem.

I interviewed state insurance commissioners, insurance regulators, civil and criminal investigators, and legal counsel from eight states (Arkansas, California, Colorado, Florida, Indiana, Louisiana, Texas, and Wisconsin). At the federal level I interviewed U.S. Department of Labor regulators and investigators from the Employee Benefits Security Administration and the Inspector General's Office. I also interviewed attorneys at the U.S. Department of Justice, current and former FBI agents with experience in insurance fraud, a litigator from a state Attorney General's office who litigated MEWA cases in the early 1990s, a local prosecutor specializing in insurance litigation, court appointed receivers and their attorneys for the two

largest entities closed by the states and federal government, a forensic accountant, insurance agents solicited to sell unauthorized coverage, and a professional association for agents.

Façade of Legitimacy

Promoters of phony health insurance utilize strategies that make the health plan appear legitimate. Their plan documents and marketing materials resemble materials from licensed insurance companies. Promoters contract with existing provider networks and issue medical cards using the name of the provider network.[6]

To promote the façade of legitimacy, they use licensed agents to market their phony products. Operators recruit agents by paying high commissions. One arrangement paid its agent consultants $50 per month for single enrollees and $100 per month for each enrolled family.

To grow rapidly, they sell to existing legitimate trade and professional associations. They also set up their own phony associations. Employers Mutual LLC, a nationwide unauthorized entity that collected $15 million in premiums and left people with over $27 million in unpaid medical bills, sold coverage to the National Writers Union, a professional association for journalists. Promoters also sold coverage through sixteen associations they established, collecting membership fees in addition to premiums from people who joined.[7] Operators of American Benefit Plans, another unlicensed entity, sold their health plan through at least seven existing associations and four associations they created — National Association for Working Americans, National Association of Working Americans, the United Employer Voluntary Employee Beneficiary Association, and the United Employee Voluntary Employee Beneficiary Association (emphasis added).[8] They enrolled over 32,000 people in forty-eight states.

Unauthorized arrangements use familiar names of existing companies. For example, the name Employers Mutual LLC resembles Employers Mutual Casualty Company, a licensed insurance company in business for nearly a century. An unauthorized arrangement (shut down by Florida's regulators) called Vanguarde Asset Group resembles Vanguard Group, a well-recognized investment management company with more than $550 billion in assets.[9] The use of names resembling existing companies misleads agents and leads consumers to believe that they are purchasing coverage from a well-known company.

Once operating, unauthorized plans pay small claims and delay paying large ones. This ensures that consumers continue paying premiums. Monthly premiums from existing and new enrollees coupled with not paying claims may mean millions of dollars every month in profit for operators of unauthorized health plans. In law enforcement circles, these schemes are called "cash cows."

Low Prices and Comprehensive Benefits

Illegal arrangements sell comprehensive coverage to small businesses, self-employed people, and professional and trade associations — those that otherwise might not be able to afford it or those looking for alternatives to their existing coverage due to double-digit premium increases. Operators set prices below market rates and enroll people without medical underwriting (regardless of their medical history). For example, according to a federal judge, Employers Mutual LLC set rates by "averaging sample rates posted on the internet and then reducing them to enable Employers Mutual [LLC] to compete with other providers."[10] That arrangement

charged a 50 year-old woman, for example, a monthly premium of $285 compared to $425 for comparable benefits from a licensed insurance company. Consumers are taken in by what they perceive as a good deal and pay premiums unaware that coverage is offered by unauthorized plans, that the company may be insolvent or potentially fraudulent.

ERISA Shield

Operators of health insurance scams claim their products are cheaper because they are not regulated by states and that they are regulated by the federal government under ERISA. Some create complex legal documents that, at least on paper, raise questions about their legal status.

Although Congress clarified ERISA twenty years ago, some ambiguities remain and operators of phony health plans continue to use ERISA preemption as a shield to avoid state enforcement actions, challenging state authority by removing cases to federal court. In the case of American Benefit Plans, although the Texas Insurance Department had a letter from the U.S. Department of Labor stating that the arrangement was subject to state regulation, one of its promoters removed the state case to a federal court. This is a tactic used by operators to delay final court action, which gives operators of phony health plans an opportunity to spend or hide assets (e.g., in offshore accounts).

Experienced Operators

The financial rewards of operating phony health plans are so great, even civil actions pose little deterrent effect. Once a promoter of an unauthorized arrangement figures out how to establish and operate it, being caught does not deter establishing new ones. For example, in 2000, Dwayne Samuels "pleaded guilty to healthcare fraud in connection with the embezzlement of some $8 million" through a phony union plan and a phony employer association.[11] He "was barred for life by the U.S. Department of Labor from having any dealings with or receiving compensation from employer benefit plans."[12] He ignored his plea agreement and operated another illegal arrangement shut down by Florida's insurance regulators in 2002.

In the case of Employers Mutual LLC, its vice president James Graf also operated Prime Care Health Networks, Inc., which was shut down by California's Insurance Department in 1998. He was also affiliated with the National Consumers Benefits Association, shut down by California's Insurance Department in 2000.[13] Around the same time, Graf became vice president of Employers Mutual LLC.[14]

Impact on Consumers

Many consumers who fall into this trap are often victimized more than once. Some agents involved with unlicensed plans repeatedly enroll their customers in unauthorized entities. For example, a licensed agent in Hawaii with a high volume of enrollees in the Hawaii HealthCare Alliance (HHA) — an unauthorized arrangement that left hundreds of thousands of dollars in unpaid medical bills and was shut down by the insurance department — enrolled HHA consumers into the TRG plan, another unauthorized arrangement, whose operators have been indicted on criminal charges in Florida and if convicted, could face up to 60 years in prison.[15]

Once consumers learn that their insurance is a scam, unfortunately in many states there are no options in the regulated market. Many people are shut out of the private market due to existing medical conditions. Victims, with medical conditions, lucky enough to find private insurance face preexisting conditions exclusion or are surcharged.

One state insurance regulator summarizes what happens when an unauthorized health plan falls apart:

> [It leaves] behind thousands of uninsurable victims with millions of dollars in unpaid claims. Everyday, good, honest people — facing personal illnesses or the pain and suffering of a loved one while trying to avoid creditors and collection agencies hounding them for payment, medical providers refusing treatment, and wondering if they are going to lose everything they have worked for all their life. These people call me everyday — they rant and they rave and sometimes they weep.[16]

GOVERNMENT RESPONSE

Both states and the federal government share oversight responsibility. As I mentioned earlier, unlike with single employer plans covered by ERISA, any arrangement covering employees of two or more employers or self-employed people is subject to both federal and state jurisdiction. Under ERISA such arrangements are called MEWAs. State and federal authority and tools vary and are complementary.

Complementary Federal and State Authority

The laws and legal tools available to states and the federal government are complementary. Accordingly, some of the most successful actions have resulted from coordinated investigations by states and the federal government.

State regulators have administrative authority such as cease and desist orders (C & D Orders) enabling states to quickly close an unauthorized entity without going to court. C & D Orders help stop the spread of an illegal plan within the state and in some cases can result in regulators' seizing assets. States also have receivership authority, which is often the only way to find assets to pay claims of victims. In one of the most successful receiverships — American Benefits Plans, which is an on-going state receivership — the receiver has been able to identify and seize $8 million in assets. To put this in context, during the last cycle of scams between 1988 and 1991, victims were left with over $123 million in unpaid medical bills. Less than $9.6 million in assets was recovered.[17]

By contrast, federal regulators must ask a federal court to close an unauthorized plan and to establish a receivership. Federal actions are much slower than state actions in this area. The U.S. Department of Labor must go to federal court and overcome a high evidentiary burden. It may take several years, in fact, to have enough evidence to prove a case in court. For example, in the case of TRG, Hawaii and Kentucky's insurance departments issued orders to shut down TRG in November 2001 (with at least 8 other states following). One state (Florida) had enough evidence for a grand jury to indict operators of TRG last year. Two years after the first state actions, the U.S. Department of Labor filed its civil complaint in federal court. Time is critical

in health insurance scam cases. The more time these operators have, the more opportunity there is to hide or spend assets – funds that otherwise could and should be seized and used to pay claims. Filing a civil case 2 years after a state takes action may mean that all assets will disappear. This means that employers and people covered by TRG will be paying their own medical bills – bills that should have been paid by TRG.

Although federal actions are slow, their effect is nationwide compared to state actions being limited within a state's borders.

Prevention and Early Detection

Prevention is the only way to protect the public against health insurance scams because once operating, it's certain that victims will be stuck with medical bills. Unfortunately, few of those most at risk – small business owners and self-employed people – know about phony health plans. A study by Nevada's Insurance Commissioner found that only 3% of small businesses in the state were aware of the existence of unauthorized insurance.[18] In response, Nevada's Insurance Commissioner launched a consumer education campaign that includes TV, radio, and print media. Through an arrangement with the Nevada's Broadcaster's Association, the Insurance Division is getting $400,000 worth of air time for $108,000 (includes all expenses and television and radio production; the combined spots will air approximately 1,000 times per month throughout Nevada.).[19]

Even broad and well-financed educational efforts, however, fail to completely prevent consumers from becoming victims. Thus, prevention must be coupled with aggressive oversight and early detection of problems. Early detection means using licensed insurance agents as the "eyes and ears" of the insurance department to identify unlicensed arrangements before they proliferate. Licensed agents are in the field and often are the first to see a potential problem when they are solicited to sell illegal coverage. Agents also lose business to illegal companies offering cheaper coverage and so have an incentive to alert regulators to problems. In a recent case in Louisiana, as a result of a tip from an agent, insurance department staff attended a marketing meeting for an unauthorized health plan. Evidence from this meeting enabled the Department to close the plan within eighteen days of the marketing meeting.

By contrast, the U.S. Department of Labor does not have this early detection tool. Reporting "unlicensed" arrangements is not necessary because ERISA plans are not licensed by the Department. Additionally, the federal government does not regulate agents and thus could not encourage nor compel agents to report suspicious activity. Not having agents to function as regulators' "eyes and ears," makes it almost impossible for federal regulators to detect problems early.

Other strategies include identifying suspicious behavior through consumer complaints. However, when consumers call, there is already a problem with unpaid bills. Nonetheless, a quick response can prevent the illegal arrangement from growing. States have developed effective strategies to utilize information from consumers. Techniques such as sharing with customer service staff names of identified arrangements and operators known to be operating in other states, special workshops for customer service staff, or automatic referrals for investigation are just some of the many techniques that states use to effectively utilize information from consumers in order to identify problems early.

Federal regulators also recognize the value in receiving information from consumers. Although the U.S. Department of Labor typically initiates investigations when there is a pattern of complaints, some of its field offices have initiated investigations when one consumer calls with a large claim not being paid. Given the long history of fraud related to MEWAs, the Department of Labor should not rely on patterns before fully investigating complaints. Instead such investigations should be automatic after receiving information from a single consumer calling with the problem of unpaid medical claims by a MEWA.

Criminal Actions

Both state insurance departments (either directly or by working with other state law enforcement agencies) and the U.S. Department of Labor investigate criminal cases. The states and the federal government have a variety of tools to hold perpetrators of health insurance scams accountable criminally. Criminal statutes for white-collar crimes, such as fraud, however, require extensive evidence, which may not always be available due to the nature of the crime. According to state and federal investigators, including ex-FBI agents who conducted undercover operations examining unauthorized arrangements, criminal cases require extensive resources.

Even aggressive civil actions against operators of phony plans, however, are not enough to stop repeat offenders. Civil actions are merely a cost of doing business to these operators. More criminal prosecutions are necessary especially at the federal level because in most cases, unauthorized plans operate nationally. For example, it could be difficult to get a Texas jury to convict someone responsible for harming a consumer in California. Similar to other white-collar crimes, unfortunately, the criminal justice system has often failed to punish perpetrators of health insurance scams with jail time.

At the federal level, it is the responsibility of the Justice Department through their Assistant U.S. Attorneys to prosecute these cases (see Table 3 for examples of federal criminal charges available). A number of factors contribute to the problem of why the Justice Department has not indicted criminally promoters of phony health plans that have been shut down in the last 3 years. One reason is jury convictions for insurance fraud can be difficult to obtain. Such trials can involve complex financial transactions and difficult insurance issues, and are often document intensive and complicated. Due to resource issues, complexity of white-collar crimes, and priorities, it may be a challenge to find a prosecutor in every U.S. Attorneys office interested in taking such a case.

RECOMMENDATIONS

Congress can and should take immediate, specific actions to slow the spread of health insurance scams and to help the victims of these scams. Perpetrators must be held accountable for their actions.

First, public awareness can help prevent the spread of health insurance scams. To that end, Congress can allocate resources and require the U.S. Department of Labor to undertake a nationwide consumer education campaign, perhaps similar to Nevada's campaign I discussed earlier. Any education campaign must tell consumers that they should check with their state

insurance department to ensure that the company they are buying insurance from is authorized in their state.

Second, Congress can clarify ERISA to prevent it from being used as a shield against state oversight. Amending ERISA to prohibit removal from state to federal court cases involving MEWAs will greatly help reduce delay tactics used by operators of phony plans and will help minimize using ERISA as a shield.

Third, Congress can require the U.S. Department of Labor to issue timely advisory opinions when a state needs help to avoid ERISA challenges to state authority by promoters of scams. It is expensive for states to litigate these issues in federal court. One state spent half a million dollars litigating an ERISA preemption issue. Often, only states investigate unauthorized plans and only states can close an entity quickly through an administrative action (without going to court). Advisory letters would also greatly benefit affected consumers by allowing states to take quick action without being forced to defend their jurisdiction when challenged on ERISA preemption grounds.

Fourth, Congress can amend ERISA to give the U.S. Department of Labor new enforcement tools such as cease and desist authority. Within constitutional parameters the Department should be given authority to seize assets without obtaining a court order first. This will help augment current state authority and empower federal regulators to be more effective. Both would help the Department to close an insolvent arrangement quickly and prevent assets from disappearing by avoiding lengthy actions in federal court. Absent such changes in federal law, only states can quickly close a phony health plan. Quick action is critical to protect victims by preventing assets from disappearing and stopping the phony plan from proliferating.

Fifth, Congress should require the Justice Department to more aggressively pursue cases against promoters of phony health insurance. Civil actions do not stop those who engage in criminal conduct. They change their name, move to another state, and repeat the scam. What is necessary are criminal actions that result in a jail sentence. To that end, the federal government should be more aggressive with criminal prosecutions.

Finally, a clear solution is to strengthen existing safety-net programs and to enact laws that will enable people and businesses to find affordable health insurance. Take away the demand, and there will be a drop in supply of illegal health plans. Absent comprehensive reforms, Congress could and should enact new laws to help victims of phony health plans who are stuck with thousands of dollars in unpaid medical bills.

Thank you for your consideration of this important issue and I look forward to assisting you as you look for ways to better protect America's workers, their families, and businesses.

Table 1. Examples of Unauthorized Health Plans, 2001-2002

Health Plan	Victims	Outstanding Medical Claims	Premiums Collected	Assets	States Involved
American Benefit Plans	40,000	$43.3 million*	unknown	$5.3 million**	Nationwide
Employers Mutual, LLC	30,000	$27 million***	$15 million	$650,000	Nationwide
Local 125	2,725	$13.3 million	unknown	$627,000	41
TRG****	12,288	unknown	$17 million	unknown	44
Vanguarde Asset Group	160	$1.2 million	unknown	unknown	Florida

* Total claims filed with the Receiver by 13,229 employers, patients, and providers. Some may be duplicate claims.

** Total of $8 million was found and collected successfully by the receiver, appointed by the insurance department, at a cost of $2.7 million in litigation fees, expert consultants, and staff resources. An additional $2 million to $3 million has been found but not yet recovered.

*** An estimated $54 million in claims have been filed. However, some of these claims may be duplicated—filed by providers in addition to the filing by the patient. Also, some claims may have been filed for individuals not eligible for coverage.

**** According to one news account, TRG covered between 20,000 and 40,000 people. According to Florida's Insurance Department, based on only 400 complaints (one consumer may have filed several complaints), there are over $2.6 million in unpaid medical bills.

Table 2. State Actions, 2000-2002

State	Date	Total # of Entities/ Individuals Affected by Order	# Entities	# Individuals
Arkansas	2002	20	13	7
California	2002	12	10	2
Colorado	2002	43	25	18
	2001	30	20	10
Florida	2002	52	35	17
	2001	31	29	2
Louisiana	2002	26	15	11
Nevada	2002	23	12	11

	2001	45	18	27
Texas	2002	104	65	39
	2001	25	21	4
Wisconsin	2000	6	5	1

Table 3. Federal Criminal Statutes Applicable to Health Care Related Crimes*

TYPE	CITATION	DESCRIPTION
ERISA	Section 411 (29 U.S.C. 1111)	Prohibition Against Certain Persons Holding Certain Positions
	Section 501 (29 U.S.C. 1131)	Criminal Penalties
	Section 511 (29 U.S.C. 1141)	Coercive Interference
18 U.S.C.	Section 2	Principals
	Section 371	Conspiracy
	Section 664	Theft or Embezzlement from Employee Benefit Plans
	Section 669	Theft or Embezzlement in Connection with Health Care
	Section 981	Civil Forfeiture
	Section 982	Criminal Forfeiture
	Section 1027	False Statement and Concealment of Facts in Relation to Documents Required by the Employee Retirement Income Security Act
	Section 1033	Crimes By or Affecting Persons Engaged in the Business of Insurance Whose Activities Affect Interstate Commerce
	Section 1035	False Statements Relating to Health Care Matters
	Section 1341	Mail Fraud
	Section 1343	Wire Fraud
	Section 1345	Injunctions Against Fraud
	Section 1347	Health Care Fraud
	Section 1349	Attempt and Conspiracy (applicable to fraud charges)
	Section 1954	Offer, Acceptance or Solicitation to Influence Operations of Employee Benefit Plans
	Section 1956	Laundering of Monetary Instruments
	Section 1957	Engaging in Monetary Transactions in Property Derived from Specified Unlawful Activity

*Not a complete listing of available charges.

[1] Mila Kofman, Kevin Lucia, and Eliza Bangit, Health Insurance Scams: *How Government is Responding and What Further Steps are Needed*, The Commonwealth Fund (August 2003) available at www.cmwf.org.
[2] Mila Kofman, Kevin Lucia, and Eliza Bangit, *Proliferation of Phony Health Insurance: States and the Federal Government Respond*, BNA Plus (2003).
[3] U.S. GENERAL ACCOUNTING OFFICE, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements,* GAO/HRD-92-40, at 2-3 (Mar. 10, 1992) (hereinafter 1992 GAO Report).
[4] In 1991, the GAO told Congress that the U.S. Department of Labor needs to issue regulations clarifying union status. 1992 GAO Report at 9.
[5] Procedures for Administrative Hearings Regarding Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA, 68 Fed. Reg. 17472 (Apr. 9, 2003) (to be codified at 29 C.R.F. part 2510 and 2570).
[6] Agents and consumers recognize well-known provider networks and don't become suspicious until it is too late.
[7] Chao v. Graf, et al, CV-N-01-0698-DWH-RAM, at 2-3 (D. Nev. Feb. 1, 2002) (court issued a preliminary injunction) (hereinafter Federal Court Order Employers Mutual).
[8]Texas Petition for Temporary Restraining Order at 5, Texas v. American Benefit Plans et al., Cause No. GV200903 (Tx. D. Travis County Mar. 6, 2002) (hereinafter ABP Petition). ABP also allegedly sold coverage through the American Association of Agriculture, Forestry, and Fishing Workers; the American Association of Transportation, Communication, Electrical, Gas, and Sanitary Workers; the American Association of Wholesale Trade Workers; the American Association of Manufacturer Workers; the American Association of Service Workers; the American Association of Construction Workers; and American Association of Professional Workers. *Id. at* 6-7.
[9] Information about Vanguard Group is available at http://flagship.vanguard.com.
[10] Federal Court Order Employers Mutual at 4.
[11]Department of Insurance (Florida): Immediate Final Order, Vanguarde Asset Group et al, Case No. 43162-02 CO, at 11 (May 10, 2002) (hereinafter Vanguarde C & D Order).
[12] Vanguarde C & D Order at 10.
[13] See *In the Matter of National Consumers Benefits Association et al*, File No. OC 110-AP at 17, Hearing Before the Insurance Commissioner of the State of California (Oct. 5th, 2000).
[14] Federal Court Order Employers Mutual at 2-3.
[15] *Commissioner Warns Against New Unauthorized Health Insurance Plan*, State of Hawaii Insurance Division, Press Release, Dec. 26, 2001. See *Gallagher, Posey Announce Felony Charges Against Operators of Unlicensed Insurance Entity*, Florida Department of Financial Services, Press Release, Apr. 14, 2003.
[16] Pamela Williams, Assistant Commissioner, Office of Health Insurance, Louisiana Department of Insurance, Multiple Employment Welfare Arrangements (2003) (unpublished presentation material) (on file with author).
[17] 1992 GAO Report at 22.
[18] InfoSearch International, *Unauthorized Insurance Awareness Study*, at 4 (Feb. 2003) (Report for the Nevada Department of Insurance).
[19] These ads will not be typical public service announcements seen in the middle of the night.