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Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed

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The United States is experiencing an unprecedented influx of unauthorized insurers selling phony health insurance. The last time this occurred, more than a decade ago, nearly 400,000 people were left with $123 million in unpaid medical bills. Unauthorized health insurance companies intentionally fail to comply with state and federal law regarding insurance regulation; they collect premiums for nonexistent health insurance; they do not pay claims, and, ultimately, they leave patients with millions of dollars in medical bills. Since 2001, four of some of the largest unauthorized plans have left nearly 100,000 people with approximately $85 million in unpaid medical bills and without health coverage. Most victims have been small businesses and self-employed people. Regulators believe this problem will only grow as premiums continue to increase at double-digit rates and people continue to look for affordable alternatives.

It is illegal in every state to operate an insurance company without a license. By not obtaining a license, unauthorized insurers are able to avoid compliance with important consumer protections, including solvency standards that ensure a company will be able to pay claims of enrolled individuals, safeguards for vulnerable populations (e.g., children with disabilities), states' health coverage continuation and conversion laws, and other consumer protections. When an unauthorized company becomes insolvent, there is no safety net, such as a state guaranty fund, to pay medical claims. Having paid insurance premiums in the belief that their medical care would be covered, victims are left to deal with often huge medical bills. Some lose their homes and life's savings. With collection agencies aggressively pursuing victims to pay outstanding medical bills, a number of patients are saddled with bad credit or forced into bankruptcy.[1]

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This issue brief highlights state and federal strategies that have been successful at identifying and closing unauthorized health plans, as well as methods of preventing their proliferation. It also makes recommendations to strengthen the roles of state and federal regulators and insurance agents as watchdogs against phony insurance.

BACKGROUND

Health insurance scams exist because there is an unmet need for affordable coverage. Those that operate phony health plans market a low-priced, comprehensive coverage option. Historically, scams have proliferated when insurance premiums increase substantially. State and federal regulators believe that the United States is currently at the beginning of the newest cycle of scams; as premiums continue their double-digit growth, many believe that there will be more victims.

Unauthorized health plans attract business by undercutting competition with low prices and accepting enrollees without medical underwriting, regardless of their past or present medical conditions. One unauthorized plan, for example, charged a 50-year-old woman a monthly premium of $285—an unusually low rate for comprehensive coverage offered in a state that allows rates to be based on one's age and health status. A licensed insurance company charged her $425 for similar benefits, which is more reflective of the rate typically charged for a 50-year-old in relatively good health.[2]

When questioned by consumers and agents, promoters of unauthorized insurance claim that premiums are low because, as group purchasing arrangements, they are able to use their collective purchasing power to negotiate lower prices from insurance companies. Additionally, they may claim that the type of plans they offer are exempt from state insurance laws—for example, union plans—and that their low premiums result from this exemption. In reality, these claims are false.

Phony plans spread because they have a facade of legitimacy. They may contract with well-recognized national provider networks, name themselves after existing companies, use marketing material that appears legitimate, or recruit licensed agents to sell their coverage. They proliferate rapidly by selling coverage through bona fide as well as phony professional and trade associations.

Once in operation, most unauthorized plans pay small claims but delay paying the large ones. This tactic deflects suspicion and gains the confidence of both consumers and insurance agents, thus ensuring continued participation and payment of premiums. The suspicions of health care providers and patients may not be aroused immediately, however, because both have grown accustomed to delays in claims payment. Not paying claims, coupled with a monthly flow of premium payments from existing and new, unsuspecting insurance consumers that sometimes can reach millions of dollars per month, can mean huge profits for promoters of phony coverage. One plan collected $1.6 million in premiums and paid only $360,000 in claims; its operator diverted more than $900,000 for personal use.[3] Another company collected $15 million in premiums while paying only $3 million in claims.[4]

Operators of unauthorized health plans are often repeat offenders. Once promoters of an unauthorized plan figure out how to operate it, they can easily establish new ones, even after being caught. Moreover, consumers who fall into this trap are often victimized more than once.

Once consumers have medical conditions, or merely medical claims, their opportunities to purchase health insurance may be impaired. In most states, self-employed individuals and others seeking to purchase individual policies must pass medical underwriting, which means they can be denied coverage because of their existing or past medical conditions. Small businesses may also have difficulty buying new coverage. Even though there are insurers in each state that offer coverage to small businesses, the premiums can be high, especially when people covered by these policies have medical conditions. In many states, once consumers get sick, they have few or no options in the regulated

market, and a number of these individuals end up buying coverage from unauthorized companies.

The First Wave: Enactment of ERISA, 1974–83

The first wave of scams followed the 1974 enactment of the Employee Retirement Income Security Act (ERISA), which federalized the regulation of employee benefits. ERISA severely restricted state authority to regulate group purchasing arrangements—a policy that led to unintended consequences. Operators of unauthorized health plans began to sell coverage through group purchasing arrangements called multiple employer trusts (METs) (Table 1). When states tried to regulate arrangements that were not subject to ERISA, including most METs, their operators successfully claimed ERISA exemption from state law.[5] However, the U.S. Department of Labor claimed not to have authority over such arrangements because most were not ERISA plans.[6] Ambiguity about whether states had authority to regulate group purchasing arrangements, as well as limited oversight by the U.S. Department of Labor, created opportunities for widespread fraud.

Congress responded in 1982 when it amended ERISA to clarify that states could in fact regulate multiple employer welfare arrangements (MEWAs) (health plans for employees of two or more employers or self-employed people). At the time, regulators believed that the ERISA amendments had had their desired effect. Although some health insurance scams surfaced, there were fewer unauthorized arrangements.

The Second Wave: Double-Digit Premium Increases and ERISA Ambiguities, 1988–92

The second wave of scams coincided with double-digit increases in health insurance premiums beginning in 1988, a year when employers faced average premium increases of 12 percent.[7] According to the General Accounting Office, increasing problems with unauthorized MEWAs from 1988 to 1991 left thousands of people without health insurance and nearly 400,000 patients with medical bills exceeding $123 million.[8]

Continued ambiguity over states' authority to regulate MEWAs was also to blame. ERISA exempts collectively bargained union plans from its definition of a MEWA, meaning that states do not regulate such plans. But uncertainty concerning what constitutes a collectively bargained union plan led to health insurance scams promoted through phony unions.[9] According to the U.S. Department of Labor, one MEWA purporting to be a union plan left 3,600 people in 32 states with some $25 million in unpaid claims.[10]

While the U.S. Congress has not clarified ERISA since 1982, the U.S. Department of Labor did issue a final regulation in April 2003 to help identify collectively bargained union plans.[11] The regulation allows for an administrative hearing to determine whether an arrangement is a collectively

Table 1. How Unauthorized Health Insurance Is Sold, 1974 to Present

Cycle of Fraud	Unauthorized Arrangements
1970s	• Multiple Employer Trusts (METs)
1988–92	• Multiple Employer Welfare Arrangements (MEWAs) • Phony unions • Employee Leasing Firms/Professional Employee Organizations (PEOs) • Association Health Plans (AHPs)
2001—	• Phony unions • Employee Leasing Firms/Professional Employee Organizations (PEOs) • Association Health Plans (AHPs) • Discount health plans

bargained plan exempt from state law. To avoid such proceedings from being used as a ploy to evade state actions, the regulation specifies that they may not be used as "the basis for a stay or delay of a state administrative or court proceeding or enforcement of a subpoena."[12] How effective this will be remains to be seen.

Third Wave of Scams: Current Crisis, 2001 to Present

Since 2001, insurance scams have been proliferating once again. State and federal regulators believe that the number and magnitude of unauthorized plans are rapidly growing and spreading around the country. Recently, two nationwide scams left 70,000 people with an estimated $70 million in unpaid medical bills and without health insurance. In the last two years, the Texas Insurance Department shut down 129 unauthorized insurance companies, affiliates, operators, and their agents whose illegal actions affected more than 20,000 Texans.[13] Florida has likewise seen a tremendous increase in the proliferation of such plans, with nearly 30,000 residents left without coverage and burdened with unpaid medical bills.[14] In December 2002, the U.S. Department of Labor reported it had 107 civil and 19 criminal investigations open nationwide.[15]

The recent influx of unauthorized plan operators can be attributed to greater demand for affordable health insurance as a result of double-digit premium increases, as well as ambiguity in federal law. In 2001, businesses with three to nine workers paid an average of 16.5 percent more for health insurance than in 2000.[16] In 2002, premiums increased by an estimated 15.4 percent.[17] Some analysts predict an additional 20 percent increase in 2003.[18] As employers face such increases, they will continue to seek alternatives to traditional health coverage. Determined to keep their insurance costs down, a number of these firms inevitably will be taken in by offers of low-priced premiums that are, literally, too good to be true.

Operators of unauthorized plans continue to use ERISA preemption as a shield to avoid state enforcement actions, selling coverage through professional and trade associations, phony unions, and professional employee organizations (PEOs). Arguably, all of these arrangements raise questions about state jurisdiction, as when phony unions sell unauthorized insurance and then claim ERISA preemption when discovered by state regulators. Selling through PEOs raises additional questions. ERISA permits only the federal government to regulate single employer health plans; both the federal government and states, however, can regulate multiple employer welfare arrangements. When asserting jurisdiction over PEOs, state regulators are forced to answer a factual question of whether a PEO is a single or multiple employer plan—a difficult challenge without a bright-line rule to guide them.

State regulators also note an increase in unauthorized insurers disguising themselves as discount health plans. While not claiming ERISA exemption, these operators claim exemption from state law because, by definition, state insurance laws apply only to insurance. In some respects, a legitimate discount plan can operate in most states free of either federal or state oversight by negotiating discounts with provider networks.

Unlike health insurance, discount plans do not pay claims. Instead, they charge consumers a monthly fee in exchange for discounts they negotiate with providers. According to state regulators, promoters of unauthorized coverage can use discount plans as a subterfuge in one of two ways: by establishing a discount plan that pays claims and therefore should be subject to state insurance law, but in fact operates without a license; or by collecting monthly fees without actually negotiating discounts with providers. In both cases, consumers are the victims.

STATE AND FEDERAL RESPONSES

The states and the federal government are trying to respond to the surge in health insurance scams through prevention, early identification, and expe-

dited action (Table 2). Successful strategies are driven by good laws and by the creativity and commitment of state and federal regulators, investigators, and prosecutors.

Prevention

Consumer Education

A study by Nevada's insurance commissioner found that only 3 percent of small businesses in the state knew that unauthorized health insurance plans exist.[19] State and federal regulators have developed education campaigns to warn small businesses and self-employed people about unauthorized plans. In addition to being a good preventive measure, regulators consider such investment cost-effective compared with the cost of identifying and closing down an active health insurance scam—one state spent more than $500,000 closing just one entity.[20] Earlier this year, the National Association of Insurance Commissioners (NAIC) began looking at ways to develop a national consumer education campaign.

Agent Education

Promoters of unauthorized health plans rely on licensed agents to sell their coverage. To prevent these plans from doing this, some state regulators require that agents receive training about unauthorized insurers before receiving their license or on an annual basis. In addition to required coursework, state regulators disseminate information through agent associations, meetings, publications, and insurance department bulletins.

Regulators believe that education about unauthorized plans must be coupled with information about penalties and agent liability.[21] Colorado's Insurance Department disseminates summaries of actions against agents who have sold unauthorized coverage to discourage agents from doing so. Agents can be personally liable for unpaid medical bills when they sell such coverage. Even experienced agents can be trapped into selling unauthorized plans.

The NAIC has developed and issued a model alert for agents, including information about their reporting responsibility and tips on how to identify phony arrangements. The alert was disseminated by many insurance departments and by the National Association of Health Underwriters, a professional association for agents and brokers.

Verification Tools

State regulators say that public education initiatives are effective only if they are supplemented with tools that give consumers and agents access to information on the legal status of an insurance company. All states examined for this study use their customer service staff to help consumers and agents verify whether a company is authorized to

Table 2. Government Responses to Health Insurance Scams

Government Response	Strategies
Prevention	• Consumer and agent education • Couple education with tools to verify whether a health plan is licensed and authorized to sell coverage in the state
Early Identification	• Use agents to identify unauthorized arrangements • Identify suspicious behavior through consumer complaints • Coordination within and among government agencies • Warn the public about arrangements operating without a license
Expedited Action	• Share evidence and perform joint investigations to close an unauthorized plan • Coordinate information and investigations between state insurance departments and the U.S. Department of Labor

sell health insurance. Moreover, insurance departments in California, Florida, and Texas use their websites to allow consumers and agents to research insurance plans. Several states use the insurance department's agent licensing divisions to respond to agent inquiries about companies.

Early Identification

Using Agents as Eyes and Ears

Insurance agents can act as informants for their state insurance department and assist in early detection of unauthorized health plans. Agents often report suspicious activity and sometimes even collect information for the insurance department. In those states that have adopted regulations based on the NAIC's model reporting requirements, agents must report unauthorized entities or face legal and financial consequences, including liability for unpaid medical bills if the entity fails to pay. So far, 17 states have adopted such regulations.[22]

Consumer Complaints

State regulators recognize that consumers can be a source of valuable information about unauthorized plans. In most cases where consumers contact the insurance department, however, they are doing so because of unpaid medical bills—indicating that a problem already exists. Some states provide special training for staff who handle consumer complaints related to unauthorized insurers. Others have special procedures for handling complaints: in Wisconsin and Arkansas, for example, inquiries about MEWAs are directed automatically to the General Counsel's office for investigation.

Federal regulators also recognize the value of consumer information. The Employee Benefits Security Administration (EBSA) trains its customer service staff to deal with health coverage scams. Although most federal investigations are not initiated until there is a discernable pattern (e.g., more than one consumer with unpaid claims), some field offices have initiated investigations when a consumer reports a large, unpaid claim—often a clear signal that a serious problem exists.

Coordination

To prevent widespread fraud, some state regulators coordinate with multiple agencies within their state as well as with other states and the federal government. Some insurance departments have formed an internal task force to watch for suspicious behavior. Colorado's insurance commissioner, for example, established a working group of division directors from consumer services, agent licensing, financial, enforcement, and forms and rate filings divisions.

Each state insurance department studied appoints a person responsible for working with other states. The NAIC has taken a leadership role in encouraging coordination among states by developing a watch list that includes information about unauthorized arrangements, their management, and where they are selling. While state officials consider these exchanges valuable, they recognize that not all states provide the NAIC with the necessary information to ensure that the list is comprehensive.

State and federal regulators also coordinate their efforts to pursue and prosecute unauthorized insurers. NAIC and EBSA, for example, exchange information about open investigations. Both state and federal officials report that such exchanges help to expedite action.

Warning the Public

Regulators believe that news releases are an effective way to notify the public that the insurance department or federal government has closed down an unauthorized insurance plan. Many regulators cultivate relationships with the media to help disseminate news.

In many cases, unauthorized plans have already enrolled a significant number of people by the time they come to the attention of regulators. To mitigate the effects of one unauthorized plan, Nevada's insurance commissioner alerted enrolled employers before taking final administrative action. Regulators made telephone calls and sent letters to enrollees indicating that their coverage had been

purchased from an unauthorized company and that, if the plan became insolvent, medical claims may not be paid. According to the insurance department, many enrollees stopped paying premiums and found new coverage.

Expedited Action

Share Evidence and Perform Joint Investigations

States have initiated joint investigations into unauthorized plans that operate in more than one state. The NAIC facilitates coordination among various state investigations by creating teams and identifying leaders. Regulators believe this is an effective way to expedite investigations and use resources efficiently.

Coordinate Between State Insurance Departments and U.S. Department of Labor

The laws and legal tools available to states and to the federal government are complementary. State regulators have administrative authority, such as cease-and-desist orders, enabling them to close an unauthorized entity without going to court. States also have receivership authority, which is often the only way to take over an unauthorized company, to stop depletion of assets, and to find assets to pay claims of victims. Federal regulators, by contrast, must go through a federal court to close an unauthorized plan or establish a receivership. Although federal actions are much slower, they can have nationwide impact—for example, when they shut down a plan that was operating in many states.

State regulators say that close coordination with federal regulators is necessary to develop evidence for a successful case against unauthorized plans. When operators of unauthorized health plans claim ERISA preemption in an attempt to avoid state regulation and delay enforcement actions, state regulators seek help from EBSA, which provides formal advisory opinions as well as informal consultations. Such advisory opinions would be helpful in every case, they say, where state jurisdiction is challenged based on ERISA. Absent such determinations, states have in some cases had to litigate ERISA challenges, a process that can be resource-intensive, can delay closing a plan, and ultimately can hurt consumers.

But federal regulators report that their own resource constraints make timely issuance of advisory opinions difficult. To help state regulators with jurisdictional questions, EBSA updated its MEWA guide for state regulators in March 2003.[23] EBSA has also made publicly available a searchable database with information about federally registered MEWAs.[24] A drawback to this database is that entities seeking to avoid state oversight are not likely to register. Also, plans are not required to report financial information to the government.

RECOMMENDED REFORMS

Although many state insurance regulators and the U.S. Department of Labor have developed some effective prevention strategies, additional steps are necessary to prevent further proliferation of unauthorized health plans.

- ***All states and the federal government should undertake well-funded education campaigns aimed at consumers and health insurance agents.***
- ***Consumers and agents must be given the necessary tools to determine whether an entity is licensed and whether it is under investigation by a state or the federal government.*** Government disclosures will help consumers and agents make informed decisions and will help stop unauthorized health plans from multiplying. One way to accomplish this is by posting open cases on government websites; when cases are closed, regulators could post the results, even if the finding is favorable to the company in question.[25]
- ***Insurance agents should receive annual training to enable them to recognize unauthorized entities.*** Promoters of unauthorized plans sell their coverage through licensed agents, without whom attracting customers would be much more difficult. State regulators must therefore hold agents who violate the law accountable for their actions. Annual training should be a condition for receiving and maintaining an agent's license.

- ***To stop the spread of unauthorized insurers, all states and the federal government must develop ways to identify such entities early.*** Given the long history of fraud related to multiple employer welfare arrangements, the U.S. Department of Labor should not wait for patterns of consumer complaints to develop before conducting a full investigation of individual complaints.
- ***State and federal regulators and investigators should share information about open cases and look for ways to better coordinate investigations.*** Some of the most successful government actions have resulted from coordinated investigations.
- ***Federal policymakers should clarify ERISA preemption to prevent it from being used to deflect state oversight.*** Absent statutory changes to ERISA, the U.S. Department of Labor should issue more advisory opinions to help states avoid ERISA challenges. Advisory letters would greatly benefit affected consumers by allowing states to act quickly to shut down plans through administrative action, rather than going to court when challenged about their authority to shut down a plan.
- ***The U.S. Department of Labor's authority should be expanded to include administrative tools, such as cease-and-desist orders, that permit immediate action.*** The complementary authority of state and federal regulators has been crucial to finding and closing illegal arrangements. But regulators would benefit from additional enforcement tools to protect victims, preserve plan assets to pay medical claims, and stop unauthorized plans from proliferating. Within constitutional limits, the Department should be given authority to seize assets without first obtaining a court order, for example. Because they would preclude the need for lengthy federal court actions, these tools would help the Department close an insolvent arrangement quickly and prevent the plan's assets from disappearing. Absent such changes in federal law, only states can quickly close an unauthorized health plan.
- ***States and the federal government should aggressively prosecute health plan operators who engage in criminal conduct.*** Civil actions are not enough. The perpetrators may change their name, move to another state, and repeat the scam. Criminal prosecutions resulting in jail sentences would serve as a more forceful deterrent to the perpetrators of health insurance scams. To improve success rates of criminal prosecutions, state policymakers could strengthen criminal penalties by making it a felony to operate and sell unauthorized health plans. Sentencing guidelines for state judges could help ensure that operators of scams are held accountable through mandatory prison terms.
- ***Federal policymakers should enact market reforms to improve access to affordable health coverage.*** Expanding access to coverage, both locally and nationally, could go a long way toward stopping unauthorized plans by reducing the demand. Unauthorized health plans thrive when insurance premiums increase.
- ***Insurance agents should be on the lookout for unauthorized plans.*** Through due diligence—asking questions about the new company and its management, as well as verifying with the state department of insurance that the company is authorized to sell the plan in the state—insurance agents can help detect unauthorized plans. These actions could also help protect agents from potential liability for unpaid medical claims resulting from sales of such plans.

NOTES

[1] Because of their bad credit, many victims are not able to borrow money to repay providers. In many states, insurance companies are allowed to consider people's credit rating before issuing policies such as car and homeowner insurance. Thus, victims of health coverage scams are at risk of not being able to buy other insurance.

[2] Telephone discussion with consumer covered by the unauthorized plan (March 6, 2002).

[3] U.S. Department of Labor, Pension and Welfare Benefits Administration, Employee Retirement Income Security Act 1999 Report to Congress, p. 15.

[4] Chao v. Graf et al., CV-N-01-0698-DWH-RAM, at 4 (D. Nev. Feb. 1, 2002).

[5] U.S. Department of Labor, Pension and Welfare Benefits Administration, Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation 1 (1992) (hereinafter U.S. Department of Labor MEWA Guide).

[6] The Labor Department now believes that it has broad authority to go after arrangements that are not ERISA covered plans when they handle ERISA plan assets, which occurs when employers covered by ERISA participate in the arrangement. U.S. Department of Labor MEWA Guide, p. 5.

[7] Henry J. Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2001 Annual Survey 14 (2001) (hereinafter Kaiser Survey).

[8] U.S. General Accounting Office, *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements,* GAO/HRD-92-40, pp. 2–3 (March 10, 1992) (hereinafter 1992 GAO Report).

[9] In 1991, the GAO told Congress that the U.S. Department of Labor needs to issue regulations clarifying union status. 1992 GAO Report, p. 9.

[10] U.S. Department of Labor, Pension and Welfare Benefits Administration, Employee Retirement Income Security Act 1998 Report to Congress 8 (hereinafter 1998 Report to Congress). See also "Court Grants Preliminary Injunction, Continuing Freeze of Assets of Trustees and Administrator of New York-Based Health Program" (press release), U.S. Department of Labor, Pension and Welfare Benefits Administration, December 29, 1998.

[11] 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 (April 9, 2003) (to be codified at 29 C.R.F. part 2510 and 2570).

[12] 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. p. 17475.

[13] Aissatou Sidime, "Health Insurance Rip-offs Rising," *San Antonio Express-News,* March 19, 2002, p. 3E. For information about state cease-and-desist orders, see Mila Kofman, Kevin Lucia, and Eliza Bangit, "Proliferation of Phony Health Insurance: States and the Federal Government Respond," *BNA PLUS* (August 2003).

[14] Discussion with lawyer who was supervisor of unauthorized entities in a state insurance department (April 17, 2003).

[15] U.S. Department of Labor, Employee Benefits Security Administration, Fact Sheet: MEWA Enforcement (December 2002).

[16] Kaiser Survey, p. 16.

[17] Projected by Hewitt Health Value Initiative, Hewitt Associates, *Annual Health Care Cost Increases National Averages* (2001).

[18] California's public employees benefits program estimates a premium increase of 20 to 25 percent. CalPERS, *2003 Health Plan and Premium Changes,* available at www.calpers.ca.gov (April 17, 2002). A UCLA study estimates private premiums to increase by 20 percent in 2003. "Health Insurance: Premiums Expected to Rise 20% in 2003," *American Health Line* (June 18, 2002).

[19] InfoSearch International, *Unauthorized Insurance Awareness Study,* p. 4 (February 2003) (Report for the Nevada Department of Insurance).

[20] Discussions with two state insurance department officials (January 21, 2003).

[21] Education also encourages agents to be more diligent in fully checking the products they sell to consumers.

[22] NAIC Reporting Requirements for Licensees Seeking to Do Business with Certain Unauthorized Multiple Employer Welfare Arrangement (MEWAs) Model Regulation.

[23] An updated MEWA guide is available at http://www.dol.gov/ebsa/publications/main.html.

[24] Database available at http://www.askebsa.dol.gov/epds.

[25] The U.S. Department of Labor should make its voluntary compliance letters (an agreement by the company to correct potential violations) available to the public via its website.

About This Study

For our examination of federal and state strategies to combat health insurance scams, we consulted with the National Association of Insurance Commissioners and with state regulators who are recognized leaders in addressing the problem. We focused on states that have had many victims of insurance fraud, as well as those in which regulators have aggressively pursued unauthorized operators. We also looked at states where the problem is just emerging. We interviewed state insurance commissioners, insurance regulators, investigators (civil and criminal), and legal counsel from Arkansas, California, Colorado, Florida, Indiana, Louisiana, Texas, and Wisconsin.

To include the federal perspective, we interviewed regulators and investigators from the U.S. Department of Labor, including the Employee Benefits Security Administration (EBSA) and the Inspector General's Office. EBSA is responsible for ERISA oversight and is the primary federal investigator of unauthorized health plans. The Inspector General investigates phony unions. In addition, we interviewed a local prosecutor specializing in insurance litigation, court-appointed receivers and their attorneys for the two largest unauthorized plans closed by state and federal government, insurance agents who have been solicited to sell unauthorized coverage, current and former FBI agents with experience in insurance fraud, and a litigator from a state attorney general's office who worked on MEWA cases in the early 1990s.

Copies of the full report, Proliferation of Phony Health Insurance: States and the Federal Government Respond, *are available from BNA PLUS. To order, call 800-452-7773 or 202-452-4323, fax 202-452-4644, or e-mail bnaplus@bna.com.*

Sources

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