Controlling Fraud in the Small Business Health Insurance Industry

EXECUTIVE SUMMARY

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ABSTRACT

This study examines fraud in the small business health insurance industry. The focus is on entities that market health insurance under the guise of being "employee welfare benefit plans," as defined by the Employment Retirement Security Act (ERISA), and which ultimately fail to pay medical claims to large numbers of their participants. The study sought to answer several basic questions: What are the larger structural causes of fraud in the small business health insurance industry; what are the principal forms that these frauds take; and what policy changes have been or might be effected that would reduce the incidence of fraud in the industry? The study relied on several types of data to address these questions: interviews with regulators, investigators, prosecutors and policy-makers, primarily in three states—Florida, Texas, and California—and Washington, D.C.; quantitative data on regulatory actions taken by state insurance departments, obtained from the National Association of Insurance Commissioners; and case studies of individual fraudulent schemes that involved numerous organizations and individuals.

The major findings from the study include the following: (1) The incidence of insider fraud in the small business health insurance industry has declined since the early 1990s, but remains a significant problem as it continues to take on new forms; (2) The ultimate sources of the problem lie in ambiguities and loopholes in federal regulatory laws that allow individuals to sell health insurance outside of the regulatory framework that oversees the insurance industry; (3) These frauds are perpetrated by organized networks of individuals and organizations who operate as "ongoing criminal enterprises"

whose form may change but whose goals remain constant; (4) Many of the victims of these crimes suffer severe physical and emotional harm and therefore these offenses should be regarded as "violent crimes"; (5) Many of these criminal schemes have a significant international component, consisting of offshore insurance companies.

I. Introduction

As the costs of medical care have skyrocketed in recent years so has the amount of money lost to fraud and abuse in the health care industry. Recent estimates suggest that this figure may be as high as $100 billion a year, or 10% of the one trillion dollars spent on health care in the United States annually.[1] This means that every 19 months, Americans spend the equivalent of the roughly $175 billion that went to bail out the savings and loan industry in the 1980s, on health care fraud.[2]

Health care fraud takes three principal forms: claimant fraud, committed by health care consumers; provider fraud, committed by physicians, laboratories and other providers of health care services; and, insider frauds, committed by individuals within the health insurance industry who use their positions to divert money from insurance plans. To date, the overwhelming focus in the public and private sectors has been on the first two forms of health care fraud. However, one could argue that insider fraud is more serious than the other two forms. Few if any insurance companies have failed because of claimant or provider fraud. They simply pass the costs on to the consumer. By contrast, when insiders create phony insurance companies which inevitably go bankrupt because they were never intended to pay off claims, hundreds and thousands of individuals who have diligently paid their premiums are often left with staggering medical bills, and worse, may be unable to obtain health care coverage in the future. Unlike the S&L crisis, in which the depositors at corrupt thrifts that failed were eventually paid off by the federal government, the victims of health insurance frauds often have nowhere to turn and are left holding the bag, while the crooks move on to set up new schemes. The victims are employees of service stations and beauty shops, small manufacturing enterprises and retailers working at or near minimum wage in often marginal

businesses--individuals "on the lower end of the socio-economic scale, those least able to protect themselves..."[3]

This report summarizes the findings from a study of fraud in the small business health insurance industry. The focus here is on insider fraud, i.e., crimes committed by the owners and operators of insurance companies that are established for the purposes of defrauding businesses and employees. The main questions to be addressed are: What are the larger structural causes of fraud in the small business health insurance industry; what are the principal forms that it takes; and, what policy changes have been or might be effected that would reduce fraud in the industry?

The approach taken stresses the systemic sources of this form of white-collar crime. While individuals perpetrate these crimes, it is the larger market conditions that create the demand for their "product" and a weak regulatory structure that allows them to commit their crimes with near impunity. Accordingly, part of the report focuses on how these larger institutional arrangements have created a "criminogenic market"--a market whose very structure and environment encourages and facilities illegal behavior--in the small business health insurance industry.

II.Data

The study relied on a variety of different data sources. Quantitative data on regulatory actions taken by state insurance departments, taken from a computerized data set maintained by the National Association of Insurance Commissioners, were assembled and analyzed. Case studies were assembled from a diverse set of sources that include government reports, newspaper articles, articles in trade periodicals, congressional hearings and internal agency reports. Probably the most important source, however, consisted of documents found in court cases--both civil and criminal--

involving those accused of participating in illegal insurance schemes. These documents, while tedious to review and assemble, provided a rich source of descriptive information about the mechanics of these fraudulent schemes. These materials represent an underutilized source of data for white-collar crime researchers and, with the advent of electronic data bases such as Lexus, and increasingly accessible source.

In addition to these data sources, interviews were conducted with approximately 30 prosecutors, federal law enforcement agents, investigators at state regulatory agencies, journalists and policy analysts. Specifically, these individuals included: attorneys at the U.S. Department of Justice in Washington, D.C.; investigators and analysts at the U.S. Department of Labor, Office of Labor Racketeering and Pension and Welfare Benefits Administration in Washington and in one field office; an assistant U.S. Attorney; a deputy Attorney General; a former deputy Attorney General, now in private practice focusing on ERISA litigation; a former and a current FBI agent; investigators and attorneys with the Florida, Texas, Oklahoma and California Departments of Insurance; analysts with the Coalition Against Insurance Fraud; staff members at the Texas Insurance Purchasing Association and with the Health Insurance Plan of California; a former official at NAIC and now a receiver for an insolvent union-sponsored health plan; and a journalist for an insurance trade publication. Two of these individuals were interviewed via telephone but the rest were interviewed fact-to-face. Approximately half of the interviews were taped and transcribed. In other cases, where taping was deemed intrusive, hand-written notes of the interviews were kept. Interviews lasted from as little as 20 minutes to as much as 3 1/2 hours.

Follow up discussions were held with several of those individuals interviewed, either face-to-face or via telephone. In these follow up discussions more specific information about individuals

or cases was often elicited which helped in the interpretation of court documents and in making connections between individuals, events and organizations.

The study began with a focus on three states--California, Texas, and Florida--where small business health insurance fraud has been particularly common and its consequences most severe. However, it soon became clear that these criminal schemes operate nationwide and that while many of their victims may have been located in these three states, the individuals behind the schemes may have been elsewhere. Thus, the scope of the study was expanded to more of a national perspective.

III. Sources of the Problem

The crimes described in this report take place in the small business or small group health insurance industry--the industry that supplies health insurance to the employees of small companies and self-employed individuals. In recent years structural changes in the health insurance industry and in its regulatory environment have transformed the small group sector into a "criminogenic industry," an industry whose very structure facilitates and encourages fraud and abuse within its ranks. These changes can be summarized as follows.

The wave of fraud in the small business health insurance industry that began in the late 1970s and continues to this day has its roots in two broad structural changes that affected the availability of health insurance in the United States. First, the last thirty years or so have witnessed dramatic changes in the health insurance industry. During this period, most large insurance companies simply left the market altogether as many large corporations began to set up their own insurance plans and as Health Maintenance Organizations (HMO's) and other managed care networks began to make significant inroads into the health care market. Particularly hard hit was the small group market,

which, because of its inherent risks and low profitability, was all but abandoned by traditional insurance companies. Those companies that remained in the market sought to increase their profits by insuring only the "cream of the crop," i.e., those individuals who were relatively health and whose medical costs would be low. As a result of these trends, small business owners saw their health insurance costs rise dramatically and many were unable to find insurance for their employees at any cost.

The second change provided the means for committing fraud in the small group market. In 1974, Congress passed the Employment Retirement Income Security Act (ERISA) the primary purpose of which was to safeguard employee pension plans. But buried within the law were important provisions that allowed non-insurance companies to market health insurance plans as "employee welfare benefits." Significantly, the law stated that such plans would not be subject to state regulations, as licensed insurance companies are, but neither would they be subject to any significant federal oversight. Thus, while ERISA's provisions were intended to make it easier for employers, labor unions and other organizations to provide health benefits to employees, they had the unintended effect of opening the doors to con artists who saw in these provisions the legal loopholes that would become the vehicles for massive frauds.

These two structural changes created an environment where demand for health benefits among small business employees was high and supply in the legitimate market was low, a situation in which white-collar criminals were able to thrive by creating what constituted, in essence, a "black market" in health insurance

IV. Forms of Fraud

ERISA recognized two basic types of employee benefit plans: (1) single-employer self-insurance plans, and (2) multiple employer welfare benefit plans, often referred to as Multiple Employer Trusts (METs). The idea behind the creation of these multiple employer plans was to give employees of small businesses access to the same affordable health insurance as the employees of large firms, by allowing employers to "pool" their employees for insurance purposes. Pooling arrangements bring down rates by creating a mix of high-risk and low-risk participants whose costs balance one another out, and by creating an economy of scale that reduces administrative expenses.

Importantly the Act exempted employee benefit plans from state insurance laws which impose requirements on insurance companies including: minimum funding standards, mandated benefits, and contributions to a guaranty fund. Thus one of the unintended consequences of ERISA was to create a regulatory vacuum in which employee benefit plans could operate without the oversight extended to licensed insurance companies. In 1983 new legislation was enacted that attempted to eliminate the loopholes created by ERISA. The new law, which came to be known as the Erlenborn Amendment, defined a new employee benefit plan, Multiple Employer Welfare Arrangements (MEWAs) and attempted to clarify regulatory jurisdiction of these and related entities. A MEWA was defined as:

> an employee welfare benefit plan, or any other arrangement (other than an employer welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit...to the employees of two or more employers (including one or more self-employed individuals), or to their

beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained - (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements..[4]

MEWAs, like METs, can take three forms: fully insured, partially insured, and self-funded. Under fully-insured arrangements a licensed insurance company provides full coverage to the association and handles the administration of the plan. Under partially insured arrangements, insurance companies provide the coverage but a third party administrator is responsible for administering the plan. Self-funded MEWAs provide all coverage themselves and their plans may be administered by a third party.[5] Under the amended version of ERISA, fully-insured MEWAs were to be exempt from state regulation except for state laws regarding "the maintenance of specified levels of reserves and specified levels of contributions."[6] MEWA plans which were not fully-insured were to be subject to any state laws "to the extent they are not inconsistent with [Title I of ERISA]."[7]

Despite the fact that the new law was meant to clarify the situtation, numerous ambiguities emerged in interpreting provisions of the Erlenborn amendments. For example, ERISA plans were required to file a financial statement with the Department of Labor (DOL), but could take as long as 19 months to do so after going into business.[8] And the DOL did not certify the plans, but would offer formal opinions about their ERISA status only after being requested to by state insurance departments. Furthermore, it would often take many months for them to respond to such a request and their response was often vague. Meanwhile MEWA crooks could continue to operate, collecting premiums for future claims that they never intended to pay, while state regulators hesitated to shut them down because of the uncertainty of their ERISA status.[9]

State regulators were not clear about the extent of their authority under some provisions. Even where the provisions regarding state regulation were clear, fraudulent MEWA operators were able to confound state regulators by simply claiming to be fully-funded by insurance carriers when they were in fact self-funded. Attempts to shut them down were often delayed as understaffed state agencies attempted to backtrack through a maze of documents presented by the operators purporting to show that their plans were backed by legitimate insurers.[10]

Thus rather then clearing up the problems caused by ERISA, the Erlenborn Admendment had the effect of creating a host of new problems and opening the door for a wide range of illegal schemes in which employees were defrauded of out of their health insurance premiums and other benefits. These schemes took three forms, each of which used different organizational vehicles: fraudulent MEWAs, employee-leasing scams, and bogus labor unions.

A. MEWA Fraud

Illegal schemes involving MEWAs began to emerge soon after the passage of the Erlenborn Amendment in 1983. Established as purported ERISA plans, they were operated as Ponzi schemes, "in which the obligations incurred today are paid from tomorrow's cash flow" and in which claims and expenses would often outrun contributions in about eighteen months to two years.[11] The schemes were able to draw in large numbers of small businesses into their bogus plans in a very short period of time by offering them health insurance at rates that were far below those of legitimate insurers - often at half the price. Because their operators would claims ERISA exemptions, state officials would have no knowledge of the plans until the complaints started

coming in from policyholders, and even then there was little they could do, given the ambiguities in the law.

One of the early entrants in the field of fraudulent MEWAs was an Irvine, California-based firm, Rubell-Helm Insurance Services, Inc. (RHISI). Beginning in 1987, RHISI began marketing health plans to the members of union locals, builders associations, nursing homes and other employee and employer groups in California, Texas, Louisiana and Florida. In their sales pitches RHISI's agents presented the firm as a fully-insured MEWA, when in fact the plans were self-insured, meaning that they were funded only by the premiums and whatever capital reserves the owners had set aside, which turned out to be none. Using deceptive strategies such as these, as well as bribing key representatives of their clients, RHISI was able to bring in revenues of more than $12 million before it closed its doors in 1989. Investigators later discovered that the principal figures behind RHISI, Michael Rubell and James Helm along with his wife Kathleen Helm, had siphoned off millions of dollars from the fund to pay for extravagant purchases that included: renovation of a ski lodge in Colorado, jewelry, Caribbean cruises, $100,000 to pay for a tailor, and $5,000 for a personal trainer for Mr. Rubell. Significant portions of the company's funds also went to pay Rubell and Helm annual salaries of $369,000. When the firm failed, it left more than $10 million in unpaid health and life insurance claims.[12]

In the wake of this and other MEWA scandals, in the early 1990s a number of states passed laws requiring MEWAs to be licensed by the state and to conform to capital reserve and financial reporting requirements. State officials interviewed for this study believed that these measures helped to reduce the incidence of MEWA-related fraud, but were quick to point out that the schemes' operators could easily move to other states that lack similar legislation or could move into other forms of health insurance fraud.

B. Employee Leasing Scams

In addition to fraudulent MEWAs, white collar criminals have used the ambiguities in ERISA to defraud health insurance consumers by using other scams, one of which involves what are known as "employee leasing organizations." Under these arrangements, individual employers "fire" their employees, who are then "hired" by an employee-leasing firms, which provides insurance, payroll and other services to the employers. By pooling the employees of numerous companies, the leasing firm has, on paper, a large enough number of employees to qualify for lower group rates. While some of the arrangements are legitimate, the insurance obtained by the leasing company "is often unsound or non-existent, consisting [of] nothing more than an in-house, unauthorized, self-insurance scheme in which the staff leasing company pays yesterday's claims with today's insurance premiums, creating yet another "Ponzi" scheme that ultimately collapses, leaving thousands of workers with health or compensation benefits."[13]

Many of these fraudulent leasing firms claim to be self or fully-funded, single-employer benefit plans and thus exempt from state regulations under the provisions of ERISA. Despite the fact that their "employees" work at different sites and for different managements, they are still technically employed by the leasing firms.

The employee leasing industry grew rapidly during the 1980s, from an estimated 98 companies in 1984 to over 2,100 firms doing business nationwide by 1993.[14] With this growth in the industry as a whole came an alarming increase in the number of these firms that failed, after taking in millions of dollars intended for health insurance, workers compensation and other employee benefits. Officials at the Texas Department of Insurance estimated that by 1991,

employee-leasing scams had defrauded residents of that state of over $19 million.[15] Similar cases were cropping up across the country.

The emerging problems in the employee-leasing industry were exemplified in a case involving American Workforce (AWF), an employee-leasing firm operated out of Dallas. AWF was established in 1988 by a James Borgelt, who was forced to remain behind the scenes of the firm because of an outstanding debt of $7 million to the IRS for tax violations at an employee-leasing firm that he had run into bankruptcy several years earlier. AWF enjoyed spectacular growth and by the end of 1990 it claimed to be one of the largest employee leasing firms in the country. This dramatic growth hid the fact that AWF was deeply insolvent, with losses totaling $7.1 million in 1990.

AWF used its association with large, reputable insurance companies to induce employers to sign up as clients. AWF agents told prospective clients that its health plan was fully-insured by Hartford Life, when, in fact, Hartford only administered the plan. Along the way AWF also used ties with the Bank of America and Great West Life Insurance to gain the trust of employers.

Employers who signed leasing contracts sent a check to AWF every month equal to the amount of their payroll plus 20 to 30% to cover benefits and AWF's administrative costs and profit. These monies were to be placed into different funds, or trusts, to be used to pay for medical benefits, a pension plan, and workers compensation premiums. However, AWF insiders did not allocate appropriate levels of funding to the medical plan, but instead diverted funds into other employee plans and siphoned off many dollars for their personal use. Even had they put the designated funds into the appropriate account, the health plan would have been grossly underfunded. The $38 per employee per month earmarked for the health insurance fund was nowhere near adequate to provide medical benefits. In other words, the health plan was simply a

Ponzi scheme that could not have possibly succeeded. By the fourth quarter of 1990, when the cash flow declined, AWF began to "slow pay" claims, delaying payment for as long as possible, and then ceased payments on health claims altogether.

AWF's motto, "We change people's lives," turned out to be all too true. In addition to those individuals who were left by AWF with unpaid medical claims - some totaling more than $100,000 - a number of former AWF "employees" were left unable to obtain health coverage after AWF went into bankruptcy. Medical problems that had surfaced while they were employed by AWF would now be considered "pre-existing conditions" by subsequent insurers. One woman who worked for a small fan distributor in Dallas was forced to borrow $5,000 to pay for a hysterectomy after her new "employer" (another leasing firm) alleged that she failed to disclose the condition on her application to the plan.[16] In the early 1990s, court rulings as well as DOL advisory opinions opened the door for states to enact laws to regulate the employee leasing industry. However, by June of 1995, only 13 states had passes such legislation.[17]

C. Bogus Labor Unions

Possibly even more vexing for regulators have been illegal schemes that take advantage of the language of ERISA regarding health plans offered by labor unions. Recall that under the original provisions of ERISA, "any plan or arrangement which is established or maintained (i) under or pursuant to one or more agreements which the Secretary [of the Department of Labor] finds to be collective bargaining agreements" is exempt from the definition of MEWAs, but is regarded as an employee welfare benefit plan. This provision in the law was intended to allow labor unions to offer health plans to their members at the affordable prices paid by the employees of large corporations

that self insure. In effect, it means that health plans offered by labor unions are exempt from all state regulations and are subject to no comparable federal regulatory standards.

In the late eighties, a number of entrepreneurs saw in this obscure provision of the law a means for perpetrating massive insurance frauds. The problem was that federal law did not define what a valid union organization was and therefore what constituted an "employee welfare plan" that had been "collectively bargained." In some instances, the operators would simply gain control over a dormant union that was originally established for legitimate purposes and would then market health plans to "associate members," persons who were unrelated by occupation or employment. In other cases, insurance crooks would simply create new unions. It turned out to be remarkably easy for anyone to start a labor union. All it took was the filing of several documents with the Department of Labor. Once established, these "unions" were then able to market health care plans to prospective "members" with sales pitches that emphasized the cost benefits that resulted from their exemption from state regulation. The plans attracted individual workers from a broad assortment of occupations, professionals, and small business owners. In some cases small firms enrolled their employees in these unions as a means to provide them with low cost benefits.

The ability of white-collar criminals to market bogus health insurance under the guise of being union-sponsored benefit plans is best illustrated by a series of case that originated in the schemes of a single individual, William S. Loeb. In the summer of 1988, Loeb created Consolidated Local Union 867, headquartered in Long Island, New York. Despite the fact that it was neither a consolidation of anything nor the 867th of anything, Loeb was able to convince officials at New York-based Empire Blue-Cross Blue-Shield to provide the organization's "members" with favorably-priced health insurance. Loeb and his associates then began an aggressive campaign to market the insurance plans through brokers around the country. Plans were sold at group rates to

individuals, many of whom were impressed by the Blue-Cross affiliation, who then became "associate members" of Local 867, even though they did not share similar occupations and despite the fact that their "union" engaged in no collective bargaining with employers.

In the summer of 1990, Loeb stopped making payments to Empire and policy-holders ceased being reimbursed for medical expenses. Soon thereafter, Consolidated collapsed with its fund depleted of assets and some $10 million in unpaid medical claims.

Following the collapse of Consolidated, Loeb and some associates immediately created another organization, the National Council of Allied Employees (NCAE). They informed many of Consolidated's former members that they could purchase insurance from the new organization. NCAE expanded its operations by selling "franchises," i.e., by chartering union "locals" around the country, for a fee. Within months, these newly-created "unions," all of which bore a striking resemblance to Consolidated, began selling health insurance plans across the country. State regulators were often suspicious of these organizations, but were limited by the provisions of ERISA and were hindered in obtaining information about the organizations because of their often complex financial structure. Many were backed by insurance from offshore companies, whose assets were difficult to verify. By the time regulators were able to finally track down the information, the organization's operators had often closed up shop and moved on.[18].

In a seemingly endless pattern of regeneration, these franchised unions would often spin off new "locals" which in turn would spawn their own offspring. For example, soon after its creation, Local 615 of the NCAE, located in Tempe, Arizona, began selling insurance to a scandal-ridden employee-leasing firm in Oklahoma City. When Arizona regulators shut down Local 615, the leasing firm's owners reorganized into Local 211, charted by a national "union," the Financial Consultants Guild of America, headquartered in Melville, New York. After being in operation for

less than two years, Local 211 was ordered to cease and desist operations by state regulators and its officers were both sued and charged criminally by state and federal authorities. The Consolidated/Local 615/Local 211 schemes well illustrate how complex organizational arrangements were often used by the schemes' perpetrators as "organizational weapons to stave off regulatory and law enforcement actions.[19]

V. Trends

One of the problems that has hindered research on white-collar crime has been the general lack of systematically-collected, quantitative data. While the federal government has spent billions of dollars developing sophisticated computerized data bases that describe street crime from virtually every angle, there are no comparable data sets on the far more costly "crimes in the suites." The absence of any reliable, systematic white-collar crime data is particularly striking in the health care system where tremendous amounts of money are lost to fraud and abuse every year.[20]

In cases involving unlicensed health insurers, the problem stems from the fact that jurisdiction over these entities is delegated, primarily, to individual states. Despite the involvement of the U.S. Department of Labor, there is no centralized coordination of their efforts. Moreover, even within state insurance departments relatively few resources are devoted to insider, as compared to claimant, fraud. As a result, data collection on insider frauds, often receives a low priority.

To some extent, the National Association of Insurance Commissioners (NAIC) represents state insurance departments collectively and acts as something of a clearinghouse for information obtained from individual departments. The NAIC maintains a number of data bases on the insurance industry, one of which is the Regulatory Information Retrieval System (RIRS). Created

in 1988, the RIRS data set contains information on actions taken by state insurance departments against individuals and firms. Included in the data set is information on cease and desist orders, license revocations, fines and penalties imposed, etc. Importantly, the RIRS data base was created to provide information to state insurance departments and others on individuals and individual companies, and not to generate statistical information. As a result, the validity and completeness of information in the system cannot be assumed. Nonetheless, the RIRS data represent the best available source of data on regulatory actions taken against licensed and unlicensed health insurers nationwide.

Before turning to the data, several caveats must first be entered. First, the RIRS data are not counts of criminal events or even persons/firms suspected of criminal activity. Rather the data describe regulatory actions taken for a variety of reasons, including operating as illegal, unlicensed insurers. Second, the data do not include actions taken by agencies other than state insurance departments. For example, the U.S. Department of Labor may file a civil suit against a fraudulent MEWA and that action would not appear in the RIRS data. Third, as mentioned above, the reliability and accuracy of the data are difficult to estimate. The data were collected to aid investigators, not conduct statistical analysis, and therefore systematic checks of their reliability have not been performed. With these caveats in mind, the RIRS data can be interpreted as providing rough measures of insider health insurance fraud.

The RIRS data contain codes indicating the type of entity against which an action was taken. One of those categories is "MEWA/MET." While this category clearly refers to only one of the three organizational forms being considered here, in fact, many of the entities designated as "MEWA/MET's" were in fact employee-leasing firms or purported labor unions, or their related health plans. On the other hand, a number of actions taken against fraudulent plans did appear in

the RIRS data but these entities were not coded as "MEWA/METs." The exclusion of these entities from the counts, produces an undercount of actions taken against the kinds of entities of concern here. Nonetheless, even with these imperfections, the data can provide rough estimates of scope and trends.

[Table 1 about here]

Table 1 shows that during the period 1990 through 1996, a total of 123 actions were taken against firms labeled as MEWA/METs. The data also show that actions against firms categorized as MEWA/METs increased from 14 in 1990 and peaked in 1993 at 29 and steadily declined in the next several years, so that by 1996 only 1 action was recorded. Despite the methodological shortcomings of the RIRS data, these statistics can be interpreted as reflecting real trends since they are consistent with the observations of many of the persons interviewed in the study. Investigators in state insurance departments and in the Department of Labor interviewed as part of this study stated that by 1995 the problem had begun to subside. Most stated they were seeing fewer of the traditional fraudulent MEWA schemes as many of the white-collar criminals who worked these scams were turning towards bogus labor unions as a favored form for orchestrating health insurance rip-offs. A similar observation was made in the Semi-Annual Report of the Office of Inspector General, U.S. Department of Labor in the fall of 1993 which stated:

> ...some operators fleeing the enhanced scrutiny given MEWAs have turned to bogus unions for refuge. OLR [Office of Labor Racketeering] investigations have revealed that these 'unions' are in fact, fraudulent and/or bogus unions. Consequently, OLR has shifted its focus

from MEWA fraud to the increasing number of health insurance schemes that are being marketed as if they were sponsored by labor unions.[21]

The government's response to crime among unlicensed health insurers has been hampered by the legislative ambiguities that allowed these entities to fall through the cracks between federal and state regulation. In the early years, state regulators complained that their efforts to control fraudulent MEWAs were frequently hamstrung by the claims of the schemes' operators to exemptions from state regulation as ERISA plans, and the failure of officials at the U.S. Department of Labor to promptly provide determinations about the ERISA status of individual employee welfare plans.[22]

Despite these problems, during the early 1990s state insurance departments began to take an aggressive stance towards fraudulent health insurers. The RIRS data, displayed in Table 2, show that of the 123 actions taken by state insurance departments against MEWAs and METs between 1990 and 1996, 77 were cease and desist orders, in which the entities were forced to stop doing business in the state. The data presented in Table 1 also show that during the period, these actions included fines and penalties that totaled 1.3 million dollars.

[Table 2 about here]

In the early 1990s the Office of Labor Racketeering (OLR) in the Department of Labor became much more proactive in the criminal investigation of fraudulent ERISA health plans. By the fall of 1993, OLR reported having closed 17 cases involving bogus health plans that, together, operated in 48 states and left some 127,000 victims with $110,407,000 in unpaid medical bills.

These 17 cases produced 55 indictments, 42 convictions and fines and restitutions totaling over $52 million.[23]

VI. Reforms

As discussed above, during the early 1990s many states enacted legislation that sought to fill the regulatory loopholes created by ERISA by clarifying their regulatory authority over MEWAs and employee-leasing firms. These new laws—many of which required licensing and registration--were effective in reducing, but not eliminating fraud among small group health insurance plans.

During the same period, while Washington debated health care reform, many states took the initiative to effect substantial changes in the health insurance markets within their states, particularly in the small group market. According to a GAO report, "between 1990 and 1995 at least 45 states passed legislation that modified the terms and conditions under which insurance is offered to small employers."[24] The substance of these measures varied from state to state but the broad goals were: "to help insure that (1) employees who want health insurance coverage will be accepted and renewed by insurers; (2) waiting periods for preexisting conditions will be short, occur only once, and be based only on recent medical history; (3) coverage will be continuous and portable, even when an individual changes jobs or the employer changes insurers; and (4) extremes in premium costs will be narrowed to fall within ranges specified by the states."[25]

While the primary goal of these small group reforms was to increase access to health insurance among small business employees, an unintended but potentially significant secondary benefit of these policies could have been a dramatic reduction in the number of fraudulent plans being marketed to desperate workers. If the illegal segment of the small business health insurance market was largely created by unmet demand for medical coverage, then an increase in the supply

of affordable legitimate insurance products, would presumably reduce the need for consumers to turn to the illegal market.[26]

As part of small group reforms, Florida, California and Texas, and other states, have created state-regulated networks of health care plans that represent more stable alternatives to privately organized programs like MEWAs. In essence, these purchasing alliances allow the states to serve the same functions as MEWAs, pooling the employees of numerous firms so that they can benefit from an economy of scale and acting as brokers linking groups of small employers and insurers.

These market reforms, then, have the potential for reducing fraud by making health care coverage more affordable and retainable for employees of small businesses. Several states have reported initial success in providing health insurance to the previously uninsured through these new programs. California officials, for example reported in 1997 that 20% of the workers insured under its HIPC program were previously uninsured.[27]

[Table 3 about here]

Yet, the proof of these programs' ultimate success lies in their ability to reduce the number of uninsureds in their jurisdictions. On this point, the data are not encouraging. Table 3 shows that in three states--Florida, Texas and California-- where substantial small group market reforms have been implemented, the proportion of the uninsured in the population actually increased in the period 1988-1995. The increases were not dramatic--ranging from 2.7% (20.0% to 22.7%) in California, to .8% (21% to 21.8%) in Florida--but are nonetheless striking given the efforts of these states to reduce their numbers of uninsureds.

VII. Conclusions

The major findings from this study can be summarized as follows:

1. Available quantitative data as well as the observations of officials close to the problem indicate that currently the problem of insider fraud in the small business health insurance industry is not as great as it was five years ago. Yet, the problem persists as its form has changed. There has been a significant decline (though not an elimination) in the number of fraudulent MEWAs, but a continuation of criminal schemes involving bogus labor unions marketing health plans.

2. The ultimate sources of the problem lie in ambiguities and loopholes in regulatory laws that allow individuals and organizations to sell health insurance policies outside of the regulatory framework that oversees the insurance industry. While some of these loopholes have been filled by changes in state laws, many remain. The primary reason why these remaining loopholes persist is because of the actions of powerful groups--primarily, large employers and labor organizations-- who find it in their interest to maintain ERISA in its current form and who resist changes to the law.

3. The frauds described in the case studies presented herein are not carried out by individual offenders operating in isolation but are perpetrated by organized networks of individuals and organizations who operate what are in essence "ongoing criminal enterprises," whose form may change but whose illicit goals remain the same. This form of white-collar crime may be referred to as "recombinant fraud" because of the evolving nature of the crimes, as the criminals adjust to

their environments by recombining old organizations with new ones in attempts to stay ahead of regulators and law enforcement agencies. In these schemes the law itself becomes a potent weapon, as the criminals will delay efforts to shut down their illegal operation by seeking ERISA exemptions in the courts. Even when their legal efforts ultimately fail, these tactics provide them with enough time to run their schemes to their natural death.

4. Similarly, insider health insurance fraud should be regarded not only as organized crime, but also as "violent crime." One of the features of white-collar crime that is often seen as distinguishing it from traditional forms of "street crime," is its generally non-violent nature. Yet, in the cases examined for this study one finds individuals who have not only suffered devastating financial loss, but also real, physical injury as a result of these fraudulent schemes. It is very important to realize that once people lose their medical coverage they very often lose access to medical care, and their health may deteriorate. Moreover, having lost their health insurance and developed serious medical conditions, they may find it virtually impossible to enroll in another health insurance plan because they now have pre-existing conditions that make them ineligible.

5. In many of the schemes analyzed here the complicated trail of agents, brokers, insurers, and reinsurers often leads off-shore. While the victims of these crimes may be "domestic" the sources of the frauds may have a significant international component. This causes significant problems for regulators who are seeking to determine the legitimacy of the organizations and particularly the assets of those entities selling insurance products in their jurisdictions. At this

point, health insurance fraud intersects with fraud in the offshore insurance industry, a significant problem in its own right.

These findings hold a number of policy implications. These include the following:

1. First, as many policy-makers have recognized, existing regulatory laws must be changed to more clearly delineate state and federal jurisdiction over ERISA-defined entities. In the last several years, significant progress has been made by a number of states in clarifying and extending their authority over MEWAs and employee-leasing firms. More states need to follow suit and enact similar laws. Similar progress has not been made in clarifying regulatory oversight over health plans sponsored by labor organizations. The Department of Labor has proposed regulations that would more clearly define what constitutes a valid labor organization. These regulations would be a significant step towards the elimination of blatantly fraudulent labor unions. Yet, as of this writing, the regulations remain stalled in the approval process.

2. Lawmakers should be cautious when considering legislation that would reduce regulatory oversight over ERISA plans. Federal legislation has recently been proposed that would allow MEWAS to operate virtually free of state regulations and be subject only to oversight by the U.S. Department of Labor. Many commentators have noted that such legislative changes would be a step backwards and would create an open door for MEWA crooks and thieves.

3. Many of the law enforcement agents and regulators interviewed for this study indicated a need for swifter, more certain criminal prosecution. The case studies support this view. Many of the individuals involved in these schemes were eventually charged, convicted and sentenced to prison. But these actions generally followed extensive civil and regulatory actions that may have slowed their schemes, but still allowed them to move to another state or create new organizations that would perpetuate the basic fraud, and allowed them to continue ripping off thousands of victims while they challenged civil and regulatory actions in the courts.

4. The driving force behind insider fraud in the small business health insurance industry is unmet demand for medical benefits among small business employees. One approach to the problem is a "market solution," i.e., a policy that alters the market so as to reduce the need for consumers to turn to the "black market" in health insurance. In recent years, a number of states--including California, Texas and Florida--have implemented small group reform measures that seek to make affordable health insurance available to small business employers and the self-employed. Fraud reduction is just one of the reasons why other states should implement similar policies.

5. One of the striking facts encountered in this study was the general absence of systematic data on the frequency, scope and consequences of insider health insurance fraud. Given the enormity of the problem, one would think that more effort would be expended on collecting such information. Proposals currently before Congress to create national data bases on health care fraud should include the collection of systematic data on these forms of insider fraud as well as data on claimants and providers.[28]

6. This study focused on white-collar crimes involving health insurance. Many of the schemes examined also involved other employee benefits. Research is needed on insider frauds involving workers compensation, pension funds and life insurance

Notes

[1]The GAO recently estimated that 10% of all health care costs go to fraud and abuse. (U.S. General Accounting Office, "Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse." GAO/T-HRD-92-29. 1992, pg. 2.) The most recent data for health care expenditures are for 1994 and show total health care expenditures totaling $949 billion. Assuming that '94-'95 growth rates will be similar to the '93-'94 rate of change (6.4%), as some analysts do, one can estimate that expenditures for 1995 exceeded one trillion dollars. (Katherine Levit, Helen Lazenby and Lakha Sivaraja, "Health Care Spending in 1994: Slowest in Decades." *Health Affairs* 15 (1996): 130-144.)

[2] The $175 billion represents an estimate of the direct costs associated with paying off depositors at failed savings and loans. The long term costs, including the interest paid by the government on bonds sold to finance the bailout, could be as high as $500 billion. (Kitty Calavita, Henry Pontell and Robert Tillman, *Big Money Crime: Fraud and Politics in the Savings and Loan Crisis*. Berkeley: University of California Press. 1997. Pg. 1.)

[3]U.S. Congress, House, Select Committee on Aging Subcommittee on Retirement Income and Aging, "Small Business and Older Workers Health Benefits: Multiple Employer Welfare Arrangements, The Problem or the Solution." Statement of Julian W. De La Rosa, Inspector General of the U.S. Department of Labor. 102nd Congress, House, First Session, September 17, 1991. pg. 75.

[4]P.L. 97-473, Section 302.

[5]Steven Cassidy, "Multiple Employer Trusts: From ERISA to the Present." *Journal of American Society of CLU*, March, 1987, pg. 62.

[6]ERISA, Section 514(b)(6)(A)(i). Here the word "contributions" refers to what are commonly referred to as "premiums" in traditional health care plans.

[7]Ibid.

[8]P.L.93-403, Sec. 102(b).

[21]U.S. Department of Labor, Office of Inspector General, *Semiannual Report to the Congress, April 1 - September 30, 1993*. Washington, D.C.: G.P.O. pg. 42.

[22]U.S. Congress, Senate, Committee on Governmental Affairs, Permanent Subcommittee on Investigations, "Fraud and Abuse in Employer-Sponsored Benefit Plans." 101st Congress, Second Session, May 15, 1990. pg. 127.

[23]U.S. Department of Labor, Office of the Inspector General, *Semiannual Report to Congress, April 1 - Sept. 30, 1993*. pg. 41.

[24]General Accounting Office, "Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance." June, 1995. GAO/HEHS-95-161FS.

[25]Ibid., pg. 4.

[26]John Emshwiller, "Cure for MEWA Fraud May Be in Clinton Health Plan." *Wall Street Journal*, October 14, 1993.

[27]N.A. "'Model' Health Care Purchasing Cooperative Sets Membership Record." *P.R. Newswire.* August 20, 1997.

[28]For a review of these proposals see GAO, "Health Care Fraud: Information-Sharing Proposals to Improve Enforcement Efforts. GAO/GDD-96-101. May 1, 1996.

Table 1. Regulatory Actions Taken Against and Penalties Imposed on MEWA/METs, by year, 1990--1996.

Year	No. of Actions	Penalties
1990	14	22,500
1991	16	820,000
1992	27	130,000
1993	29	118,000
1994	27	150,000
1995	9	40,000
1996	1	20,000
Total	123	$1,300,500

Source: NAIC, Regulatory Information Retrieval System.

Table 2. Disposition of Actions Taken Against MEWA/METs, 1990--1996

Disposition	Number
License Suspended/Revoked	2
License, Other	2
Certificate of Authority Suspended	3
Certificate of Authority, Order	4
Cease and Desist	77
Consent Order	13
Temporary Restraining Order	3
Show Cause	5
Rehabilitation	2
Liquidation	3
Monetary Penalty	5
Settlement	1
Other	3
Total	123

Source: NAIC, Regulatory Information Retrieval System.

Table 3. Percent of population under age 65 who were uninsured in 1988 and 1995.

	1988	1995	Change
California	20.0	22.7	+2.5
Texas	26.0	27.0	+1.0
Florida	21.0	21.8	+0.8
U.S.	15.2	17.4	+2.2

Sources: General Accounting Office, "A Profile of the Uninsured in Selected States." GAO/HRD-91-31FS. February, 1991. Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured." Washington, D.C. 1996.