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Association Health Plans: Will Trump Proposal Invite Repeat Crime Wave?

By Matthew J. Smith

The rapid spread of fake health plans that bilked 200,000 Americans and saddled many with financially ruinous medical bills a decade or so ago has ignited mounting concerns about a plan by the Trump Administration to authorize so-called Association Health Plans.

The new proposal risks inviting a wave of fake health plans like the crime spree that swept across the U.S. like germ warfare in 2002-2004. A steady flow of defrauded health-insurance buyers incited national headlines. State and federal regulators struggled to contain the cons at first. Regulators finally crashed the party and shut down the schemes in concert with federal crackdown.

Flash forward: President Trump promised Americans ''great, great healthcare'' in October 2017, touting wider access to lower-priced group health plans. His executive order directed the U.S. Labor Department (DOL) to let more small businesses band together by forming so-called Association Health Plans.

Up to 11 million Americans working for small businesses or as self-employed individuals, plus their families, lack employer-sponsored health coverage, DOL says. The proposal would expand the federal criteria for AHPs to offer coverage as large group health plans exempt from small-group and individual consumer protections, with looser federal oversight. In theory, more small businesses and self-employeds could buy coverage across state lines, at lower cost and with fewer federal restrictions.

Sen. Rand Paul (R-KY) says the final regulation is headed for release in May. If that date holds fast, this heightens the urgency to ensure a rule that firmly protects against expected scams. DOL did not respond to requests to confirm the May release.

AHPs may be a well-intended idea. Yet the elysian promise has potentially damaging tripwires. The proposal harbors oversight ambiguities and potential enforcement gaps that could put small businesses and individuals at risk of being exploited by scam artists who, history shows, inevitably will seek to exploit weakness in the new AHP system. The money will be too good for marketers of fake health plans to pass up. Relaxing standards for AHPs thus greatly shrinks the regulatory margin of error.

Especially important is to both clarify that states are fully empowered to regulate AHPs, and apply state-based standards to AHPs without limit. Bogus plans will exploit any limits on states to steal from businesses and individual consumers. A regulatory no-man's land would open wormholes of vulnerability through which bad actors could slip in and set up fake health plans. Diluting state oversight thus would be a fatal flaw, which the Coalition Against Insurance Fraud and many other groups across the consumer protection spectrum oppose.

The proposed rule acknowledges AHPs have a sorry history of fraud, deception and insolvencies. It also agrees relaxed standards could invite scams: ''the flexibility afforded AHPs under this proposal could introduce more opportunities for mismanagement or abuse. . .''

Harken back to 2000-2002, when America was wallpapered by the rapid spread of fake health plans. Large spikes in legitimate heath premiums plus a sagging economy created a double whammy for people vulnerable to health-insurance hoaxes. Stressed small businesses needed affordable coverage for employees. Con-

sumers were anxious to cover themselves and their families.

Predators sold phony group health plans nonstop throughout the U.S. They promised full benefits at below-market premiums via the mass bargaining power of association health plans supposedly sponsored by trade groups (and unions). People merely had to join the ''association'' to cash in.

The names sounded real enough: American Trade Association. American Benefit Plans. National Association of Professionals and Technicians. National Association of Working Americans. The pretend associations welcomed anyone with an open checkbook, whether or not the buyers had any tie-in to the group's claimed mission.

Anxious consumers and small businesses took the bait. They bought junk policies *en mass*. The health plans were worthless pieces of paper; the associations were empty shells.

At least 144 fake health plans operated around the U.S., the GAO said in a report. Promoters sold bogus coverage to more than 15,000 employers covering about 200,000 policyholders. The pseudo plans stuck victims with at least $252 million in unpaid claims, plus stolen premiums.

Employers Mutual LLC alone left at least 30,000 people without health coverage, yoking them with more than $27 million of unpaid medical claims. American Benefit Plans stuck at least 40,000 people with $28 million of unpaid medical bills.

Many scams were national in scope, marketing useless health plans across state lines. Millions of dollars in premiums flowed into the operators' bank accounts, and then were transferred off-shore. Plan overseers ran the scams from small offices headquartered in modest strip shopping centers or other low-profile locales to avoid regulators. Marketers in boiler rooms cold-called people. Deceptive emails and even unwitting health-insurance agents sold the ersatz coverage. The plans typically paid smaller claims to placate policyholders, yet refused to pay larger claims.

Some policyholders were saddled with large and unaffordable medical bills, often jeopardizing their health or lives.

A Texas child named Bobby Lee Horn had brain cancer. His parents thought they had decent health coverage, only to discover their plan was phony and wouldn't pay his $250,000 of medical bills.

A California freelance writer suffered permanent vision damage when she was forced to delay eye surgery after her health insurance proved to be worthless. NASCAR champion race driver Pete Orr had 300 victories—and cancer. The once-athletic Florida man ended up with $250,000 of medical bills when his health plan refused to pay up. Orr died in 2002, leaving his grieving widow to auction off his trophies and other memorabilia to help pay the bills.

At first, state and federal agencies were unready for the speed with which those scams spread, and their wide national scope. A determined crackdown eventually rolled up the plans with increasing force, largely decapitating most. Convictions and sentences still are being handed down. Bart Posey helped bilk 17,000 consumers through his Tennessee-based American Trade Association and Smart Data Solutions. He was convicted in January 2018. He'll spend up to 30 years in federal prison when sentenced April 30.

This was hardly the first AHP-style influx. Fake health plans have a history of mass-deceit and insolvencies dating back to at least the 1980s.

Important for the current debates over AHPs, in those two earlier waves health plans often exploited a no-man's land between state and federal oversight. Some lied that the federal Employee Retirement Income Security Act of 1974 (ERISA) exempted their plans from state oversight. Many illegal operators stalled state regulators and consumers by spreading disinformation that ERISA exempted them from state regulation. The delays allowed fake plans to keep luring policyholders and stealing their premiums.

Against that historical backdrop, today's AHP proposal's looser standards would let associations of employers or self-employed workers:

- Create an AHP solely to offer health coverage;
- Form an AHP without a common interest other than a shared industry (e.g., carpenters or wedding videographers) or geography;
- Offer health insurance that qualifies as large-group coverage to all of its employer members, regardless of size. This includes self-employed persons and sole proprietors (''working owners''); and
- Form an association or group whose sole purpose is to provide group health coverage. It would not have to be a pre-existing organization.

To help control fraud and abuse, an association sponsoring a group-health AHP also must be real, the proposal also asserts. The association must have an organizational structure, and be controlled by members. That means a governing body, bylaws, and other legal strictures. The association's employer members would have to govern through a board or other direct or indirect employer control. This standard could be meaningless for dishonest operators. They can still create sham organizations by lying that members control the association, and that it meets all the ERISA requirements.

Equally, looser standards could trigger a rush of phony AHPs sold around the U.S. Ambiguities in oversight and enforcement expand that fraud potential.

''Furthermore, there is no requirement that an entity be in existence for any period of time. These entities can spring up with ease and target unsuspecting small businesses and self-employed people,'' Mila Kofman, head of the Washington, D.C., health exchange and a leading expert on fake health plans, wrote in a comment letter to DOL.

This makes it all the more urgent that federal regulators *and* states jointly oversee AHPs. DOL brings considerable federal enforcement ability to the mix — a vital enforcement pillar despite enforcement gaps. The FBI, IRS and other federal watchdogs also can weigh in with heavy-caliber weaponry, since many scams will operate nationally, across state lines.

The states also wield potent tools and frontline experience to prevent, discover and shut down counterfeit health plans. States thus must retain full authority to regulate AHPs domiciled or selling coverage within their individual borders, *and* oversee plans that operate across state lines.

Given the high stakes, these justifiable concerns augur for a cautious, deliberate DOL vetting before AHPs take effect. More open input and discussion between stakeholders and DOL will be especially helpful. A sprint to market would be a mistake.

Empowering State Oversight

Does the AHP proposal allow well-empowered state enforcement to protect Americans from fraud and abuse? Seemingly ''maybe'' in theory, though potentially ''not so much'' in practice. Ambiguities in the proposal raise significant questions about whether it could dilute or preempt state oversight in practice. And, there is a history of fake health plans falsely arguing they are exempt from ERISA, even when their plans are not exempt. This gambit seeks to evade state law. Scammers will continue defrauding victims while cases are litigated.

The measure says it ''would not modify the States' authority to regulate health insurance issuers or the insurance policies they sell to AHPs.'' It also says states and the feds have ''joint authority'' over AHPs.

In fact, Congress clarified that states have broad authority to regulate self-insured AHPs by amending ERISA in 1983. It's called the Erlenborn Amendment. The action sought to protect consumers from widespread fraud and insolvencies by Multiple Employer Welfare Arrangements — of which AHPs are one type.

Today, states can require AHPs to obtain licenses as insurers with that state's insurance department . . . impose solvency standards . . . require enough reserves to pay claims . . . and launch market-conduct and financial examinations. Just as important, states have authority to investigate the plans for suspected fraud.

Even so, the proposal's ambiguities raise concerns about state authority to continue regulating AHPs. Among exploitable gateways:

State oversight exemptions. DOL says it might allow broad (individual or class) exemptions of some self-insured AHPs from state insurance regulation. How widely will exemptions be granted—are they a way to work around state oversight? If a state tries to impose its own AHP regulations, will the Administration grant exemptions in response? Could federal exemptions be numerous and broad enough to impede or overrule state oversight? While clarification will be helpful, it would be unsound public policy to limit state authority in any way.

Consistency with ERISA. State regulation can't be ''inconsistent with ERISA,'' the proposal says. So what happens if a given state imposes rules that differ from DOL's interpretation of ERISA? Would a state's prohibition or restriction against new self-insured AHPs, for instance, run afoul of federal rules? The history of scams shows that crooks use any and all ambiguity to lie, cheat and steal. Any preemption will have bad implications for states trying to protect their residents.

Systemic Concerns

Other potential gaps raise added concerns. For example:

Resources. DOL would need to commit more staff, funds and other resources to address AHP abuse and mismanagement, the proposal admits. A new bureaucracy may be needed. DOL already oversees 2.3 million health plans, and about that many welfare benefit plans such as life and disability insurance.

DOL's proposed FY 2019 budget seeks just 15 new employees to oversee AHPs. Yet the agency would have to hire 150 more staff and spend an added $136 million over 10 years to oversee expanded AHPs, the Congressional Budget Office found in 2005. DOL had one employee conducting AHP oversight or enforcement for every 8,000 plans, the GAO found in 2007.

Can DOL alone handle the increased oversight load if bogus AHPs spread in volume?

DOL also gained cease-and-desist authority under the Affordable Care Act in 2010. That may help, though only if DOL has resources and the will to enforce. Notably, DOL has used this authority just once in the ensuing eight years and does not license AHPs.

Similar enforcement burdens would land on state shoulders — virtually an unfunded anti-fraud mandate. Diluting state regulation of AHPs would leave large and potentially damaging enforcement gaps.

State Oversight: Need for Speed

All of this circles back to the need to clarify that states have broad oversight authority before the new AHP proposal is adopted—and most important, after it is implemented. The measure's success depends on it. So does the health, safety, and even lives of policyholders. State insurance oversight could bring irreplaceable enforcement tools to the fast-moving AHP fray.

States know how to move faster and more-nimbly against bogus AHPs. State regulators, for instance, will need to exercise their authority to issue emergency cease-and-desist orders without going to court. States issued cease-and-desist orders against 41 scam operations during the 2002-2004 wave, while DOL issued three.

States also can require self-insured AHPs to be licensed as insurers. Reserve and capital requirements, market conduct exams, solvency oversight, background checks of plan operators and other requirements can strengthen the state safety net further. All of these powers can help weed out many bogus health plans before they get going, and uncover wrongdoers that do operate.

Maintaining state regulatory power can help avoid sole or even primary reliance on slower-moving criminal actions. There is no lengthy wait to convince state prosecutors to take a criminal case. Nor are there long delays to get on the trial calendar, or extensive time needed to build and try a criminal case with its higher burden of proof.

Most states also have fraud units that can launch criminal investigations quickly, in concert with cease-and-desist orders and other administrative actions.

And state receivership authority can help find assets to pay victims. State receivership laws would let insurance departments take over financially ailing AHPs, uncover and seize assets, and stop or greatly slow the wanton theft of stolen premium dollars.

State regulators also are closer to the action in their backyards. They have built-in early-warning systems—canaries in the anti-fraud coal mine—that are harder for the feds to match from back in Washington, D.C.

Health-insurance agents can serve as hyper-local eyes and ears to expose emerging scams. Consumer complaints to fraud hotlines run by state insurance departments can sound alerts.

Thusly armed, state insurance departments can quickly make their residents aware of AHP scams. Regulators have close ties to local news media, business

groups and other influencers that can quickly sound statewide fraud alarms.

State field intelligence can greatly benefit DOL as well. Those insights can warn DOL that AHP scammers are operating, helping trigger a potent federal crackdown in concert with states. State field intel also can provide vital evidence for criminal actions by the FBI and Justice Department.

State insurance regulators greatly tightened their joint enforcement network after the 2002-2004 influx of bogus plans. States have grown far more adept at discovering and sharing urgent fraud trend intelligence with each other. They continue improving their reaction time and enforcement tools. Much of this heightened action flows through coordination by their hub group, the National Association of Insurance Commissioners.

States are hardly silver bullets, however. Some states have more resources and have more-sophisticated oversight capacity than others have. Questions also linger about whether tech-savvy plan operators can outgun less-tech-savvy state insurance departments. Expect the full gamut of modern marketing tech tools — mass emails, texts, tweets . . . continuous social-media blasts . . . slick websites with easy-to-use signup engines . . . mass cold calls . . . and so much more.

Still, *in toto,* states impose a large and proven enforcement shield that DOL cannot match on its own.

Learn From History

Fraudsters are inevitable, no matter how much armor we build into any new AHP system. Unscrupulous promoters will try to exploit every crevice of ambiguity and vulnerability. There's simply too much money available to steal. Adroit swindlers likely are already thinking about plans of attack. Why make life easier for them?

DOL should clarify oversight ambiguities and ensure a fully empowered role for states as part of a hardened state-federal fraud defense bulwark. Equally, clear rules of the regulatory road, backed by necessary resources, will greatly tighten the AHP safety net. The overriding goal: signal to con artists that the risks are too high and rewards too low.

Let's learn from history instead of repeating it.

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